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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS†

GREETINGS AND GOOD WISHES FOR THE NEW YEAR

The December issue of CALIFORNIA AND WESTERN MEDICINE will be in the mails some weeks in advance of the Christmas and New Year's season. In anticipation, however, the OFFICIAL JOURNAL welcomes the opportunity of extending its heartiest felicitations for the approaching holidays to all members of the California Medical Association. If, perhaps, the monetary rewards for services have not been as great as in more prosperous years, physicians have at least the satisfaction of knowing that much of their work has made the lot of many beings more livable; and that thought, alone, should bring gladness to the heart.

The healing-art guild is truly a noble one, and its faithful disciples are fortunate in being able to render that peculiar aid which makes the world, for a host of persons, a far brighter and more attractive place.

May the physicians of California, therefore, in the year to come, be recipients of the kindest thoughts and expressions from grateful patients, and may they also ever be animated by an earnest desire to move forward, shoulder to shoulder, in meeting the problems which confront both scientific medicine and modern day civilization. To all, then, a Merry Christmas! and a Happy New Year!

PROPOSED VOLUNTARY MEDICAL SERVICE PLAN

Special Session of California Medical Association's House of Delegates Called for December 17.—What may become an item of major historical moment in the annals of the California Medical Association is the action taken by its Council, at a meeting on November 12, in authorizing the call for a special session of the Association's House of Delegates, to be held in Los Angeles on Saturday, December 17. At that time there will be presented for consideration a report from the Council, outlining the basic principles for a plan of voluntary medical and hospitalization service, designed to permit citizens, belonging to certain income bracket groups, to avail themselves

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

of such opportunity on a prepayment basis. The initial and tentative thoughts contemplate the voluntary coöperation in the plan of practically all of the more than 6,000 members of the California Medical Association.

* * *

Organized Medicine Is Admirably Adapted to Take Up This Work.—Without going into details, it should be evident that the members of the California Medical Association are in a pivotal position to participate in a plan of such large-scale medical service. Their state, county and local organizations, with a personnel already in past years, carefully selected, present excellent groups through whose members medical service of proper quality may be offered and rendered. As a matter of fact, the large number of citizens who need the proposed medical service are today, in the majority of instances, patients of the physicians who make up the California Medical Association. The problem, therefore, is not one of placing new patients under the supervision of our members, but of devising methods whereby these patients will find it less of a hardship, financially and otherwise, when unforeseen illness or injury come to them.

* * *

"Adequate Medical Care" Is Not a Simple Matter.—The solution of that problem is not a simple matter, as may be witnessed in the massive amount of survey and other literature that has come off the press in the last several years. Nor is this a new problem for the California Medical Association, our organization having spent, or misspent, probably more money (certainly in excess of $50,000 of its funds on the "California Medical Economic Survey" on an investigation of medical-care needs of citizens) than any other of the constituent state units of the American Medical Association. But even those funds, if their expenditure has aided in the crystallization of the thought of members on the needs and procedures of medical care, may be construed as well spent.

* * *

Initial Efforts with Nonprofit Hospitalization Organizations.—As is well known, our first practical efforts in this work, other than the promotion of better orientation of the problems among the members themselves of the Association, may be said to have aided in the creation of the three nonprofit groups: the first in the Sacramento region, the second that of Alameda and the third in the Los Angeles area, in which hospitalization on a prepayment basis was made available to citizens. Time has shown, however, that California citizenry wishes more than hospitalization protection; in short, the people want medical care, with hospitalization included.

* * *

California Medical Association Council Has Been Constantly Studying Medical Care Problems.—The members of the Council of the California Medical Association, upon whom has devolved the responsibility of carrying forward the instructions of the House of Delegates, as given at succeeding annual sessions of the Association, have been obliged, of necessity, to give much serious thought to these matters; and in their own meetings, and through the Department of Public Relations and special committees, there has been constant effort to find the paths to more adequate medical service, both as regards distribution and as to quality of service, to be made available to all California population groups.

In the tentative plans in mind, just referred to, the indigent and near-indigent citizens, who now receive treatment in the county and other hospitals of California are, for the moment, left out of consideration. It is the group of citizens above these in income, but who, particularly in the recent years of economic stress and strain, have found it most difficult to meet the expenses of unforeseen illness, that the proposed plans of the California Medical Association, as submitted through the special committees and Council, are most concerned.

More than this, at this time and in this column, it is not possible to state; for we do not know what will be the conclusions reached by the delegates when they meet on December 17 to consider these and related matters. On other pages* appear articles and paragraphs, shedding sidelights on some of the problems at issue. Their perusal, hasty and otherwise, is commended to the readers of the OFFICIAL JOURNAL. In the meantime, careful thought should be given to these important matters by all members of the California Medical Association, and opinions should be freely exchanged with officers and delegates, to make more certain that actions decided upon will have the approval of members, particularly in relation to basic principles.

It is to be hoped, therefore, that the special session of the House of Delegates will make for a real advancement in the practical solution and realization of these big problems of adequate medical care, at least so far as those problems affect the citizens of California.

STATE HUMANE POUND ACT DECISIVELY DEFEATED!

Scientific Medicine Supported by a Two-to-One Vote.—By a vote of more than two to one, Initiative Proposition No. 2 (the State Humane Pound Act)—a proposed law, so written as to confuse voters concerning its real purpose, and with a title legal in form and yet equally as misleading as the text—was rejected, November 8 last, when more than a million votes were cast by Californians against it.

Thus, animal experimentation—as sponsored by physicians of California, acting through the California Medical Association, the California Society for the Promotion of Medical Research, the Public Health League of California and allied friends—received the decided approval of California's

* For official notices, see page 470; for other articles, see pages 500–503.

electorate. The campaign in behalf of the measure, led by the antivivisectionist groups, and supported by one of the country's leading newspaper chains—which fairly outdid itself in full-page display of emotional articles about "man's dear friend, the dog!"—and further fortified through expensive billboard, radio and other advertising media, was carried on in most aggressive fashion. That these efforts failed but adds to the greatness and glory of the decisive victory attained. So once again, not in legislative chambers, but this time on a direct appeal to the people, the proponents of this type of law enactment have been deservedly worsted.

* * *

Antivivisectionists Failed in Efforts to Make California a Guinea Pig.—Elsewhere in this number of CALIFORNIA AND WESTERN MEDICINE appear some references to the battle, and these, with others that have been given space in recent issues, complete the story of the 1938 struggle against those who, from emotional or other incentives, would have made the State of California the guinea pig for a brand of legislation, to be tried out, one after the other, in the years to come, in other states of the Union. With the experience gained in this last of the many fights which have been made necessary, each biennium, as the antivivisectionist cohorts repeatedly have marshalled their supporters at legislative sessions behind proposed statutes that would have seriously handicapped scientific medicine in California, it should be possible for physicians in other commonwealths (possessing in proportion far fewer faddists than the large number who, in search of climatic and what-not lures, are now resident in our State) to wage successful battle against similar machinations.

The present fight is now over, with results, so far as prevention of law enactment is concerned, entirely pleasing. The money and efforts necessary to defeat Proposition Two, would give rise to less satisfactory reflections, were it not for the issues involved, so important to the public health interests and welfare of the people. Those ends amply justified the ways and means found necessary, in order to achieve such a victory.

* * *

Thanks of the Association to All Who Rendered Aid.—It is not possible to name all who are worthy of praise. Mention has already been made of the California Society for the Promotion of Medical Research and the Public Health League of California. In every county medical society of the California Medical Association, officers and committees worked unremittingly in the distribution of post cards to be sent to patients, and in the dissemination of educational literature and other printed matter, for offices and homes, and for various display. The loyal and generous support of the members of the Woman's Auxiliaries is worthy of special mention, their contribution being most difficult to estimate in terms of money, because so massively and wholeheartedly given. Credit is also due to local groups who, on their own initiative, supplemented the work of the central distributing centers in San Francisco and Los Angeles, by devising special literature and placement of advertisements in the local press. To all who gave aid, the thanks of the California Medical Association are given. The coöperation everywhere rendered was most gratifying to the Association's Council, because that body was called upon to determine the kind and amount of expenditures to be authorized. The decided endorsement, by the citizens at large, of the stand taken by California's medical profession, especially at a time when civic vagaries of all kinds are so frequently promoted and espoused, is most reassuring. It permits physicians to look ahead, and with confidence, towards other problems which must be faced and solved.

DEL MONTE ANNUAL SESSION: MAY 1–4, 1939

Scientific Papers and Exhibits, and Hotel Reservations.—Members of the Association who have in mind papers which they desire to present before one of the twelve scientific sections at next year's Del Monte annual session, should communicate promptly with the Secretary of the proper section.*

Request is also made that members wishing to display exhibits in the scientific section, should write promptly to the Association Secretary. Members of the Committee on Scientific Work may also be consulted.†

Because of the possibility of medical service plans being inaugurated, as referred to elsewhere in this department, the attendance at Del Monte will probably be greater than usual. Members who intend to be present, therefore, should send their request for reservations to the Hotel Del Monte, Del Monte, California, at an early date.

The prompt coöperation of members in the items referred to above is requested and will be appreciated.

VISITATION BY PRESIDENT W. W. ROBLEE TO COUNTY MEDICAL SOCIETIES IN NORTHERN CALIFORNIA

Official Position Means Official and Personal Responsibility and Service.—"All is not gold that glitters," and, likewise, official positions in state and county medical societies are by no means, empty honors.

True, to be elevated to office in a medical society is an honor; but if official service is not rendered in return, promotion to office is neither a credit for the society or the recipient. Organized medicine, in the present day, faces too many serious problems to permit any physician to accept office, unless it is in his heart and mind, to give service in return to the fellows who so honored him.

* * *

President Roblee's Two Thousand-Mile Journey.—It was our privilege to accompany

* Names of officers of the scientific sections are printed in each issue, on advertising page 6.

† For names of members, see committee roster on advertising page 2.

President W. W. Roblee of Riverside in a journey of two thousand miles, through the northern section of California, as he made a tour of visitations to the county medical societies in that portion of the State. It was most heartening to learn, at first hand, how earnestly and ably our colleagues are serving the people of their districts, and how interested and alert they are to present-day issues in scientific and organized medicine. To attend some of the smaller society meetings, and be present with colleagues who had convened especially to meet the president of the California Medical Association, and hear the message brought by him, some members traveled as much as one hundred miles, often over difficult mountain roads. For, let it not be forgotten that the problems in some of these more sparsely settled districts are as important to the physicians there resident, as are those confronting members who live in the larger urban and metropolitan areas. Be it also said, to the credit of our colleagues in these districts, that they are as keen to meet all the responsibilities to their profession and to their patients as are physicians living in the large cities. As an example, the story revealed by practically every society visited, of wholehearted and wise coöperation in battling the State Humane Pound Act, made one take more than ordinary pride in what has been accomplished.

A few words, in addition, on the generous donation of time and effort of President Roblee who, in this particular visitation tour, left his practice for more than two weeks. It should be remembered that officers and members of the Council, in attending meetings which total weeks, if not months, each year, are also out of pocket the money they would have earned had they been active in their own offices; their reward being the pleasure that comes from so serving their fellows and in promoting public health and medical interests. Truly, today, in contrast to years ago, when organized medicine, in so far as official duty was concerned, expressed itself often, in little more than about once each month, presiding at a medical meeting, is a very different kind of responsibility. From which the conclusion may be drawn that a physician who is not willing to serve, and to serve generously, should decline official positions. Scientific and organized medicine alike need active workers, and only such should accept office.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 470.

In 1937 there were 80,322 deaths registered in California—the largest number ever to be registered during a single year. The death rate was 12.3 per thousand estimated population, which is the highest death rate for California since 1928, when the rate was 12.5. The pandemic of influenza in 1918 brought the highest death rate ever recorded in California, 17.7 per thousand population. There were 57,683 deaths registered that year, 15,600 more deaths than were recorded during the preceding year.

EDITORIAL COMMENT†

X-RAY THERAPY FOR SINUSITIS

The treatment of chronic paranasal sinusitis has always been a difficult and, at times, a rather discouraging problem in the practice of medicine. Local medical treatment, short-wave diathermy, and surgery have all been used with varying degrees of success. Any rational measure which will improve this distressing condition is worthy of consideration.

The good results secured with x-ray therapy in other inflammatory lesions, such as boils and carbuncles, suggested that this mode of treatment might be of value in the treatment of sinusitis. The reports in the literature are quite encouraging. Butler and Wooley[1] report one hundred cases of sinusitis treated with x-ray. Thirty-one per cent became symptom-free, 50 per cent were improved, and 19 per cent showed no change. In a second series of 450 cases these authors report 36 per cent symptom-free, 55 per cent improved, and 9 per cent unchanged. Rathbone[2] treated seventy children with sinus disease and stated that 57 per cent were cured, 28 per cent were improved, and in 15 per cent there was no change. These cases were followed from one to three and one-half years. Good results have also been reported by others.[3-6]

During the past few years we have treated quite a number of cases of sinusitis with radiation and have been favorably impressed with the outcome. X-ray therapy is not a panacea or cure-all for sinusitis; however, the results indicate that it is a valuable adjunct in treatment, and a more general use of x-ray therapy for this condition is warranted.

The effect of radiation on sinusitis has been studied experimentally in cats (Fenton-Laisell). It appears to be due primarily to an early destruction of the lymphocytes in the infected lining membrane. There is a gradual reduction in the thickness of the lining mucous membrane, probably due to the destruction and removal of innumerable lymphocyte cells. The cilia and cellular elements of the mucous membrane show no evidence of injury from the radiation. The amount of radiation administered is so small as to be entirely free from danger, not producing even the slightest erythema. Ordinarily three or four treatments are sufficient.

The cases that respond best are those with chronic low-grade sinusitis, with edema and thickening

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Butler, F. E., and Wooley, I. M.: Roentgen Therapy in Chronic Sinusitis, Radiology, 23:528 (Oct.), 1934.

2 Rathbone, R. Rhett: Roentgen Therapy of Chronic Sinusitis in Children, Am. J. Roentgenol., 38:102 (July), 1937.

3 Osmond, John D.: Roentgen Therapy of Acute Infections of the Antrum and Frontal Sinus, Am. J. Roentgenol., 10:374 (May), 1923.

4 Hodges, Fred M.: Roentgen Therapy of Infections of the Nasal Accessory Sinuses, Am. J. Roentgenol., 39:578 (April), 1938.

5 Smith, H. B., and Nickel, A. C.: The Treatment of Subacute and Chronic Sinusitis by Roentgen Radiation, Am. J. Roentgenol., 39:271 (Feb.), 1938.

6 Williams, A. J., and Bryan, L.: Roentgen Therapy in the Treatment of Nonspecific Respiratory Diseases, Radiology, 26:45 (Jan.), 1936.

of the lining membranes. These cases complain of headache, pain over the sinuses, and of postnasal discharge. Sinuses that contain free pus and are not draining should not be treated by x-ray but by the usually accepted procedures. After drainage has been accomplished, radiation may be used in addition to the prescribed treatment. Radiation therapy is of value in treating children, especially in those cases in which the physician hesitates to recommend surgery. Frequently a great deal can be accomplished for patients with sinus disease whose symptoms persist despite numerous surgical procedures. Following radiation, there is usually both subjective and objective improvement. The patient's symptoms disappear, and follow-up roentgenograms will show clearing of the sinuses. Occasionally there is an increase in the nasal secretion the first day or two after treatment.

It is not our contention that all cases of sinusitis should be treated with x-ray therapy. The coöperation of the otorhynolaryngologist is invaluable, and he is best qualified to determine which cases are suitable for treatment with radiation. Certainly, cases should not be treated indiscriminately. X-ray therapy will not cure all cases of sinusitis, but it is, nevertheless, a valuable adjunct in treatment, and worthy of recommendation in selected cases.

1930 Wilshire Boulevard.

LOWELL S. GOIN,
Los Angeles.

CALIFORNIA'S FIGHT AGAINST TUBERCULOSIS

The physician knows perhaps better than anyone else of the insidious nature of tuberculosis—of the importance of early diagnosis and of early treatment. Even today, too many deaths are caused by advanced cases of tuberculosis—cases which, had they been brought to the attention of the physician earlier, might have been cured.

The promotion of the early diagnosis of tuberculosis is one of the chief objectives of the sixty-three affiliated tuberculosis associations throughout California. The state-wide program, supported by the annual sale of Christmas Seals, provides for the prevention of tuberculosis through the use of the tuberculin test, the x-ray, and follow-up nursing programs. To date, these case-finding methods have been carried on almost exclusively among school populations, and during the past three years more than 270,000 school children have been examined for tuberculosis. The most recent survey, that of 70,000 in California schools, revealed approximately 300 cases of adult type tuberculosis—275 of these among the students themselves, and twenty-five among teachers and other school employees.

A large number of the county tuberculosis associations in California have inaugurated follow-up nursing programs to supplement their local tuberculin testing surveys. In these, the public health nurse brings the parents, relatives and friends of students found to be infected to their family physician for examination, and every effort is made to uncover the source of infection. Numerous unknown cases are brought to medical attention in this manner. The early discovery of active cases of disease by the public health nurse and the family physician is not only an important factor in reducing the annual death toll from tuberculosis—4,428 lives every year in California alone—but it is also important in preventing the spread of infection to others in that community.

However, as large numbers of the school population are being examined and safeguarded against the spread of tuberculosis, the next task appears to be in industry—a field in which little, as yet, has been accomplished. Tuberculosis is basically a problem of the working man—it claims its highest toll between the ages of 15 and 45—and may be termed a disease of industry. It is the outstanding chronic disease of industrial workers. The challenge of the early diagnosis of this disease among industrial groups is perhaps the largest tuberculosis control problem facing California today.

To bring the private practitioner in California a fuller understanding of diagnostic techniques the present plan of consultative clinics conducted by the California Tuberculosis Association, upon the invitation of the local county medical society, has been of far-reaching importance. These clinics have been held in over thirty counties to date, and have given local physicians the opportunity of conferring with chest specialists upon difficult problems in diagnosis.

It is toward the early diagnosis of tuberculosis that California's sixty-three local tuberculosis associations are striving, and for which these associations conduct their annual sale of Christmas Seals.

45 Second Street.

W. F. HIGBY,
San Francisco.

Death and the Workers.—As a consequence of the triumphs of science and their application in the health field we find this startling contrast in mortality data: fifty years ago 94 per cent of all mortality from disease was from acute illness, chiefly infectious; today 75 per cent of all mortality from disease is from chronic illness. Ten diseases take this toll of three out of four of our deaths. Listed according to the death rates for which they are responsible are: Heart disease, cancer, pneumonia and influenza, cerebral hemorrhage, nephritis, tuberculosis, diabetes, diarrhea and enteritis, appendicitis and syphilis. From seven of these ten diseases—all but cerebral hemorrhage, diabetes, and appendicitis—the death rates mount steadily as income goes down.

The death rate from respiratory tuberculosis is seven times greater among unskilled workers than among professional workers; three times greater among skilled workers than among the professional. Death rates from diarrhea and syphilis are twice as high for the unskilled as the professional; cancer's toll of the unskilled worker is 50 per cent higher than of the professional. The death rate from all causes is more than twice as high for the unskilled worker as for the professional.—Roche.

Disinfection of Diphtheria Bacillus Carriers.—After reviewing some of the methods formerly recommended for the disinfection of diphtheria carriers, and after pointing out some of their shortcomings, Meyer describes his own method.

He applies a 3 per cent alcoholic solution of methyl violet by means of a cotton compress to the tonsils and to the nasal mucous membrane. This solution not only spreads rapidly over the surface but also enters the folds and crypts. The only disadvantage of the solution is that it stains. The applications are made two or three times weekly.—*Journal of the American Medical Association.*

ORIGINAL ARTICLES

CHRONICALLY ILL AND CONVALESCENT PATIENTS: THEIR CARE IN INSTITUTIONS*

A MEDICAL AND STATISTICAL SURVEY OF THE INMATES OF THE LAGUNA HONDA HOME, SAN FRANCISCO

By J. C. GEIGER, M.D.
ROSLYN MILLER
AND
HILDA F. WELKE
San Francisco

DISCUSSION *by Ray Lyman Wilbur, M.D., Stanford University; Benjamin W. Black, M.D., Oakland; E. S. Loizeaux, M.D., San Diego.*

THE problem of the care and treatment of diseases and injuries is a community's primary responsibility. The prevention of preventable diseases and accidents should likewise engage the community's best efforts. Consequently, there should be facilities for hospitals for the tuberculous; for the mentally diseased; for the isolation of ordinary and obscure communicable diseases; for purely medical cases; for surgical conditions, especially the orthopedic care of fractures that are readily amenable to treatment; and, finally, for the care of the injured with its related ambulance services. The problem as a whole demands modern buildings, expensive equipment, and high standards of professional staff. The cost of such intricate care has steadily risen, despite tremendous gifts of charitable service by doctors of medicine and the student nurse, and the tax-supported institution has of late been subjected to decidedly close scrutiny.

In connection, however, with the treatment of the sick, there appears to be another problem, and one which may be forgotten or neglected, namely, the care of the convalescent and the chronically ill. The social significance of these allied conditions, especially chronic illness, which the thoughtful health official knows to be the chief cause of invalidism and death, has not been given the importance it deserves. Communal resources for the rehabilitation of the patient and his return to some fruitful occupation, possibly incidental to the particular disease, should be carefully studied, indexed, and conserved. It is for this reason that a medical survey of the patients, both ambulatory and hospital, of the Laguna Honda Home of the San Francisco Department of Public Health, was primarily undertaken. The factual data obtained are to be used for the study of future requirements for care of the chronically ill patients in this and other institutions of the Department of Public Health.

LAGUNA HONDA HOME REPORT FOR THE YEAR 1937

The first medical survey made of the records of patients at the Laguna Honda Home was undertaken for the year 1937, and resulted in an analysis of 2,961 cases: 1,902, the inmate population on January 1, 1937; and the remainder, 1,059, new entries or reëntries of patients discharged prior to that date. In this total group, 77 per cent were male, and 23 per cent female. During the year, 662 (or 22 per cent) died. At almost daily intervals, patients are discharged, some to the San Francisco Hospital of the Department of Public Health, either because of tuberculous infections or for x-ray therapy; some to accept benefits under the provisions of the old-age pension law; a few are runaways; and some leave because they have been rehabilitated to some extent and have found outside the institution a means of livelihood or source of care. In almost no instance can these releases be considered permanent, especially the aged pension group, and a constant flow of traffic in readmissions and discharges results. So, on December 31, 1937, there remained in the institution a total of 1,877 inmates, out of the 2,961 patients who were living in the Home at the beginning of the year, or who had applied for admission and had been accepted during the year's progress.

EFFECTS OF OLD-AGE SECURITY LEGISLATION

The effect of old-age security legislation is becoming more manifest at the Laguna Honda Home. Four years ago the population consisted of approximately 25 per cent hospital cases, and 75 per cent ambulatory. Recently, the case load has become divided equally between hospital and ambulatory groups, and the demand for hospital beds is constantly increasing. In 1937, 90 per cent of all cases admitted were hospital cases, and 60 per cent of this group were on old-age pensions. There is now a waiting list for hospital beds, many of the persons on the list being old-age pensioners. The follow-up of the aged who have resided in the institution, and who have reached the age of sixty-five and become the recipients of old-age pensions, reveals many interesting facts. Inmates of this type are supervised at the Laguna Honda Home as to food, as to exercise, and as to health. On leaving the institution, however, because of the old-age pension, it is found that the pension allowed ($35 per month) is apparently insufficient, or the personal budget is not regulated satisfactorily. The result, accordingly, is noted in the physical findings when these individuals of necessity must return to the institution.

RECENT TRENDS

Since March 1, 1938, a noticeable change has occurred in the character of the admitted case load. Ambulatory patients, for the first time, are applying for admission to the Laguna Honda Home. Apparently, this may be due to the so-called "recession" where the demand for employment, part-time or otherwise, of the aged group has ceased. Moreover, it is stated that this type of case has great difficulty in returning to relief rolls.

With a population of nearly 1,900, between 600 and 700 of these are kept busy with definite daily tasks, for which a number receive small cash compensation. The main result noted is that, from a social-economic standpoint, the individuals are benefited by their work, inasmuch as idleness breeds

* From the Department of Public Health, City and County of San Francisco.

TABLE 1.—*Classification According to Diagnosis*

	Male		Female		Totals	
	Total	Per Cent in Group	Total	Per Cent in Group	Total	Per Cent in Group
Arteriosclerosis	1,252	55	396	58	1,648	56
Heart disease	875	38	279	41	1,154	39
Heart disease and arteriosclerosis	748	....	216	....	964	....
Hypertension	336	15	172	25	508	17
Hypertension and arteriosclerosis	265	....	136	....	401	....
Syphilis	442	19	61	9	503	17
Syphilis and positive blood Wassermann	60	....	4	....	64	....
Syphilis and positive spinal fluid Wassermann	31	....	2	....	33	....
Hemiplegia	253	11	121	18	374	13
Hemiplegia and arteriosclerosis	162	....	88	....	250	....
Hemiplegia and hypertension	59	....	52	....	111	....
Gonorrhea	348	15	7	1	355	12
Gonorrhea and arthritis	43	....	2	....	45	....
Arthritis	192	8	108	16	300	10
Arthritis and gonorrhea	43	....	2	....	45	....
Alcoholism	251	11	30	4	281	9
Alcoholism and neuritis	33	....	10	....	43	....
Senility	177	8	97	14	274	9
Fractures	164	7	59	9	223	8
Cancer	168	7	52	8	220	7
Hernia	173	8	16	2	189	6
Dementia	81	4	83	12	164	6
Dementia and senility	31	....	38	....	69	....
Prostate disease	131	6	0	0	131	4
Tuberculosis	71	3	16	2	87	3
Tabes	67	3	11	2	78	3
Tabes and positive blood Wassermann	41	....	5	....	46	....
Tabes and positive spinal fluid Wassermann	32	....	4	....	36	....
Nephritis	53	2	21	3	74	2
Drugs	61	3	7	1	68	2
Drugs and dementia	1	....	0	....	1	....
Neuritis	48	2	16	2	64	2
Neuritis and alcoholism	33	....	10	....	43	....
Diabetes	40	2	19	3	59	2
Diabetes and arteriosclerosis	26	....	16	....	42	....
Asthma	37	2	11	2	48	1.6
Parkinson's	37	2	8	1	45	1.5
Sclerosis	28	1	7	1	35	1.0
Cirrhosis of liver	31	1	4	0.6	35	1.0
Rheumatism	19	0.8	10	2.0	29	1.0
Rheumatism and heart disease	14	....	9	....	23	....
Epilepsy	19	0.8	9	1.0	28	0.9
Thyroid disease	2	....	18	3.0	20	0.7
Other diagnoses	69	3.0	28	4.0	97	3.0

discontent. Furthermore, the use of inmate help, besides the additional happiness and contentment accorded the workers by their employment, is a substantial saving to the taxpayers and reduces the per diem cost per patient in the operation of this institution.

CLASSIFICATIONS

A surprising fact is to be noted in an examination of the tabulation (Table 2): Ages on admission—40 per cent of the entire group entered the Home under sixty years of age; 26 per cent in the age group, fifty to fifty-nine years; 10 per cent, forty to forty-nine; and the remaining 4 per cent, under forty years. So large a group, incapacitated for gainful employment before reaching the age of sixty, gives rise to speculation as to the social, economic, or physical factors operating to produce the condition, and brings up a question as to whether or not efforts toward rehabilitation can be so directed as to cause a return of at least some of this group to economic independence.

The colored population is only about 4 per cent of the entire inmate group and includes Chinese, Japanese, and Negro. The greatest number in the colored group is found among the Chinese. (Table 3.)

TABLE 2.—*Ages on Admission*

Total in Groups			
Age	Male	Female	Total
Under 30 years	15	0	15
30-39 years	59	20	79
40-49 years	211	83	294
50-59 years	608	165	773
60-69 years	833	186	1,019
70-79 years	438	159	597
80-over	119	65	184
Per Cent in Groups			
Age	Male	Female	Total
Under 30 years	.7	0	.5
30-39 years	3.0	3.0	3.0
40-49 years	9.0	12.0	10.0
50-59 years	27.0	24.0	26.0
60-69 years	36.0	27.0	34.0
70-79 years	19.0	23.0	20.0
80-over	5.0	10.0	6.0

While no special significance is attached to the fact, it is interesting to note that 50 per cent of the inmates are foreign-born, and only 11 per cent are natives of San Francisco. (Table 4.)

A review of the figures on the marital status (Table 5) of the inmates shows a total of 85 per cent either single, widowed or divorced, indicating that dependence upon aid outside the home increases in those groups where the individual is forced by circumstance to rely solely upon himself. Only 15 per cent of the group were married and entered, presumably, from established homes.

TABLE 3.—*Classification According to Race*

Color	Male	Female	Total
White	2,188	661	2,849
Black	22	11	33
Chinese	47	5	52
Japanese	20	0	20
Other	5	1	6

The colored population is about 4 per cent of the total.

TABLE 4.—*Classification according to Place of Birth*

Birthplace	Total	Per Cent in Group
San Francisco	336	11
United States	1,136	38
Foreign	1,487	50
Unknown	2	....

TABLE 5.—*Marital State*

	Male	Female	Total	Per Cent in Group
Single	1,182	115	1,297	44
Married	330	126	456	15
Widowed	538	385	923	31
Divorced	231	52	283	10
Unknown	2	0	2	0

Because of the repeated discharges and subsequent reëntries, it is almost impossible to estimate the length of stay, the time for which these individuals are dependent upon municipal support. A computation, however, has been made on the length of stay (Table 6) in the case of the 662 inmates who died during the year. Of these, 412 (or 62 per cent) of the total group remained less than one year, in periods ranging from one day to a full year's time. Twenty per cent remained for periods from one to five years, 12 per cent from six to ten years, while the remaining 6 per cent were for varying lengths of stay, one inmate staying under the care of the institution for thirty-six years.

The type of previous employment seems to have had but little effect upon the incidence of certain

TABLE 6.—*Classification According to Length of Stay in the Institution*

Length of Stay	Male	Female	Total
0- 1 year	308	104	412
1- 2 years	39	10	49
2- 3 years	25	5	30
3- 4 years	27	3	30
4- 5 years	20	2	22
5- 6 years	20	1	21
6- 7 years	15	4	19
7- 8 years	8	3	11
8- 9 years	15	0	15
9-10 years	14	2	16
10-11 years	6	1	7
11-12 years	7	1	8
12-13 years	5	3	8
13-14 years	2	1	3
14-15 years	1	1	2
15-16 years	3	0	3
16-17 years	0	0	0
17-18 years	0	0	0
18-19 years	1	0	1
19-20 years	2	0	2
20-24 years	0	0	0
24-25 years	0	1	1
25-29 years	0	0	0
29-30 years	1	0	1
30-36 years	0	0	0
36- years	1	0	1

TABLE 7.—*Classification According to Occupation*

Occupations	Total Male	Total Female	Total Total	Heart Male	Heart Female	Heart Total	Hemiplegia Male	Hemiplegia Female	Hemiplegia Total	Hernia Male	Hernia Female	Hernia Total
Sedentary	88	18	106	45	4	49	13	1	14	7	0	7
Sedentary—moderate physical	166	35	201	68	16	84	32	8	40	15	1	16
Moderate physical	436	284	720	233	109	342	72	42	114	49	5	54
Physical	550	22	572	282	13	295	71	2	73	58	1	59
Hard physical	457	0	457	211	0	211	49	0	49	36	0	36
Housewife	0	294	294	0	129	129	0	66	66	0	8	8
Mental	61	13	74	31	7	38	13	1	14	7	1	8
Unknown—none	5	12	17	5	1	6	3	1	4	1	0	1

Per Cent of Totals in Above Groups

	Total	Heart Per Cent	Hemiplegia Per Cent	Hernia Per Cent
Sedentary	106	46	13	7
Sedentary—moderate physical	201	42	20	8
Moderate physical	720	47	16	7
Physical	572	52	13	10
Hard physical	457	46	11	8
Housewife	294	44	22	3
Mental	74	51	19	11
Unknown—none	17	35	24	6

diseases, which might conceivably be adversely affected by physical exertion or lack of it. Table 7 indicates results obtained in checking the occupations of inmates upon admission.

MEDICAL CASE HISTORIES

Because of the purpose for which this survey was initiated, interest centers on the medical case histories. In so selected a group, certain diagnoses are expected definitely to appear. So it is not surprising that arteriosclerosis is found in 56 per cent of the cases, heart disease in 39 per cent, with hypertension in 17 per cent of them and hemiplegia in 13 per cent. A high incidence of venereal disease was found, either present or in past histories, 17 per cent indicating syphilis; 12 per cent, gonorrhea. A total of 1,933 cases showed that blood Wassermann tests had been done, 13 per cent of which were positive; and 314 spinal fluid Wassermann tests, 29 per cent of which were positive. No other disease of the degenerative type was found present in more than 10 per cent of the cases. Neither alcoholism (9 per cent) nor cancer (7 per cent) assumed an importance that might have been anticipated in this age-weighted group. The low incidence of tuberculosis (mostly in past histories) is accounted for by the fact previously stated that active cases of tuberculosis are discharged to the San Francisco Hospital for treatment. Table 1 affords in greater detail an analysis of diagnoses found.

MORTALITY FIGURES

To the original compilations in this survey have been added a tabulation on certain causes of death, and a comparison between the inmate deaths at the Laguna Honda Home and the deaths in the age group above thirty-five years in San Francisco as a whole (Table 8). The outstanding difference, as

TABLE 8.—*Mortality*

Cause of Death	Deaths in Laguna Honda Home	Per Cent in Group	Deaths in San Francisco (thirty-five years—over)	Per Cent in Group
Arteriosclerosis	12	2	72	0.9
Heart disease	469	71	2,749	33
Syphilis	25	4	114	1
Hemiplegia*	4	0.6	537	7
Cancer	90	14	1,191	14
Nephritis	7	1	593	7
Diabetes	3	0.5	197	2
Cirrhosis of liver	6	1	216	3

* This title includes cerebral hemorrhage, cerebral embolism and thrombrosis, cerebral softening and hemiplegia.

is to be expected, is the excess of inmate deaths from arteriosclerosis, heart diseases, and syphilis. Cancer deaths show the same ratio in each group. The comparison serves only to emphasize the fact that the survey involves a specialized group, in which additional weight is necessarily given to such governing factors as age, social, economic, and physical conditions.

EMERGENCY HOSPITAL SERVICE OF SAN FRANCISCO

A service designed primarily to care for the injured, and acute and chronic ill is the Emergency Hospital Service. In 1937, 21,000 ambulance calls were made and 11,500 transfers between the Emergency Hospitals, the San Francisco Hospital, and the Laguna Honda Home. During the year, 71,633 patients were admitted for treatment. Indicative of the fact that younger-age groups are subjected to greater hazards, and demand emergency care more frequently, is the following tabulation on the age distribution of these cases, in which 66 per cent of them fall into the group below forty years of age:

Age Distribution of Emergency Hospital Cases

1937		
Age	Total	Per Cent in Group
Under 5 years	4,681	7
6-19 years	13,940	19
20-39 years	28,811	40
40-59 years	17,024	24
60-over	5,459	8
Unknown	1,718	2

OTHER MUNICIPAL SERVICES

Two other services municipally supported are the care of the convalescent and the service of city physicians. Neither of these services is confined wholly to the care of the old-age group or the chronically ill in the city-wide population. During 1937, the city physicians reported a total of 16,259 service calls, including home visits, office calls, and repeat visits. The home visits, which constitute nearly 80 per cent of all calls, were made to those persons too ill to pay office visits, or to the chronically ill under investigation for admission to the San Francisco Hospital or Laguna Honda Home.

Most of the convalescent care available for patients from the San Francisco Hospital is given children. The Hassler Health Home affords care for the adult convalescent from tuberculosis; the Laguna Honda Home, for the aged and infirm. While, in addition to the above, care is available for women at the Ladies' Protective and Relief Home, there is no other institution offering care for men, although both men and women, if living in their own home, may be allowed the services of a housekeeper or visiting nurse during convalescence.

Another benefit given the chronically ill, aside from hospitalization or when hospitalization is not indicated, is the filling of prescriptions through the pharmacy at the San Francisco Hospital. It is estimated that in 1937, 5,250 prescriptions of this nature were handled in addition to the 10,400 furnished to the Central Chest Clinic of the Department of Public Health for dispensation to its patients.

COMMENT

The term "chronic illness" carries with it the suggestion of incurability in the aged, when it may be also applied to early, middle, and late life. The congenital defects of birth, the high and crippling rate of accidents of modern life, especially from the automobile, and the condition of those severely handicapped because of lesions of the heart and kidneys, all contribute their share of cases of the so-called chronics. Chronic illness, therefore, is not synonymous with old age. It is possible for persons to adapt their occupation satisfactorily to changed conditions incidental to the accompanying disease. The prevention of chronic disease challenges the attention today of the thoughtful health official, and public welfare demands organized efforts to assist the chronically ill. In this connection, the control of cancer is one of the most fruitful frontiers.

There are many economic problems created within the family by chronic illness. Mounting costs of care and the protracted course of the illness will directly affect every member of the family. This problem is generally recognized in the case of tuberculosis, but the cardiac and the kidney cases generally must shift for themselves. Trade-unions, with their prescribed hours and standardized wages, have never viewed the problem of the handicapped part-time, pieceworker with any degree of intelligence. Moreover, workmen's compensation laws authorize agreement between employers and employees as to certain diseases and injuries incidental to the employment, but the noncompensable injury and disease has never been envisaged or discussed until in recent years. There are other problems of the chronically ill whose families waste enormous sums on healing cults and the patent medicines so attractively advertised and so readily purchased. Someone has estimated such costs as at least a billion dollars a year. There is abundant evidence as to what has been accomplished in the control of communicable disease in San Francisco. Certainly, any attack, if only partially successful, on chronic diseases will conserve life and resources. Finally, the chronically ill have the right to every expert medical care which the modern, well-trained physician and the well-equipped institution can render. It will be of public interest, will add a new chapter to preventive medicine in San Francisco, and produce fertile fields for teaching the student of medicine in disease problems that will engage his future work more and more, to observe the consummation of contemplated hospital plans in the Laguna Honda Home of the San Francisco Department of Public Health.

101 Grove Street.

DISCUSSION

RAY LYMAN WILBUR, M.D. (Stanford University).—As Doctor Geiger's paper indicates, we are facing some entirely new responsibilities in the care of the aged and conva-

lescent. The Social Security legislation and the general attitude that the Government will take care of those who are rich in years and poor in financial resources are sure to have their effect.

It is surprising to find that 40 per cent of the entire group entering the Laguna Honda Home were under sixty years of age. We have built up our institutions with the idea of taking care of those who were incapacitated by mental or physical condition from earning their own living. It looks now as though a goodly number of those coming to our institutions will apply for entrance upon the showing of age alone. With the many benefits that are coming to the American, with greater knowledge of disease and nutrition, it looks as though the younger people of the future would have quite a contract on their hands to take care of those who have retired from the race.

It is about time for us to review our whole attitude toward chronic illness, the employment of the handicapped, and the care of the convalescent. This means that we shall need to restudy the functions of all of our public institutions. The manifestations of disease are changing, the age level is rising, and the attitude of many toward receiving free care is undergoing modification. As these statistics presented by Doctor Geiger and his associates indicate, we are in for a period of readjustment which we must face without preconceptions if we are to obtain answers that are satisfactory or reasonable from the financial standpoint.

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Benjamin W. Black, M. D. (Alameda County Hospital, 2701 Fourteenth Avenue, Oakland).—The medical and statistical survey of the inmates of the Laguna Honda Home in San Francisco, as presented by Dr. J. C. Geiger, has been read with great interest.

The Alameda County set-up for the care and treatment of the chronically ill, as well as the services rendered by other institutions, covering emergency care and necessary medical services to the indigent sick, correspond closely to the plan outlined in Doctor Geiger's report. The results of the survey presented by Doctor Geiger, in connection with the classifications presented according to diagnosis and ages on admission, are very similar to that found in our own chronic institution. Several years ago it was determined that, as a policy, only persons whose physical or mental handicaps and disabilities were such as to require institutional care would be admitted for continued care in the county institutions. Prior to that time there had been a comparatively large number of individuals who were able to live outside but who preferred to remain in our Fairmont Hospital, set aside for the custodial care of such patients. The basis of the policy, as stated when reviewed, indicated that even though persons able to live outside required relief at the expense of the county, their maintenance other than in institutions was desirable. By maintaining such patients at public expense on the outside, it permitted the county to avoid expensive construction projects and the maintenance of institutions for the care of such patients, when actually the daily expense for maintenance on the outside was no greater than the general expense of maintaining them after the institutions were built. This has rather changed the picture of the care of aged persons who are not ill and who, with safety, may be maintained outside of institutions.

Fairmont Hospital of Alameda County has today 810 inmates and patients. Of this number, 505 are actually hospital-bed cases, and 305 are ambulatory, but all of them are suffering with disabilities which prohibit their living in the community and prohibit their being discharged from the institution. For several years past, careful attention has been directed toward their rehabilitation and discharge, even though when discharged certain maintenance must be supplied at the expense of the public. Last year, in our Fairmont Hospital, with its 820 beds, there were 2,053 admissions with a total of 3,619 patients being treated during the year; with a total number of hospital days' supply, which includes the number of days each patient and inmate was in the institution, amounting to 295,945 days. The average hospital days for each patient totaled 102.47. There is included in this number of patients, however, the care of chronic tuberculosis. An institution is set aside for such care and the set-up is not duplicated in the other two county institutions. To this department there are admitted far-advanced cases suffering with tuberculosis, as well as cases requiring chest surgery. Our experience in segregating such cases, with considerable attention toward their physical and mental rehabilitation, has been most encouraging. Some thirty-three patients in this department received major surgery during the year. Some seventy patients, spoken of as inmates, were discharged under the old-age pension, but many of them have returned when it was found that they were unable to adjust themselves to the requirements outside. Our average age limits are a little higher than those mentioned by Doctor Geiger. We find fewer in the lower income groups and more in the extremely old-age groups than he has indicated. Classification of diseases is approximately as mentioned by him.

I am in agreement with Doctor Geiger in some of his conclusions, but particularly where he states that the term "chronic illness" carries with it the suggestion of incurability in the aged. Our own experience over the past ten years has led us to believe that many persons thought of as chronically ill and incurable are capable of more or less recovery and subject to a degree of rehabilitation that permits a return to the community life. Chronic illness is not synonymous with old age. Much more attention should be given to the type of patients covered by Doctor Geiger's survey, and the thoughtful health officials must continue to utilize all facilities to assist in the return of such persons to community life rather than maintain them for the long period of years, suggested by his survey, in institutions at the expense of the public.

It is noticeable in our services that physicians themselves are less responsive to the need of the chronically ill, not only in institutions but in practice. This is probably a natural consequence of the continued desire on the part of the physician and the patient, the tangible evidences indicating recovery must be present if successful medical care is being applied. A change of psychology in dealing with the chronically ill, particularly in the community, would be one important step in the rehabilitation of such persons.

The paper is worthy of careful attention, and I hope that it will stimulate similar studies where chronic patients are being cared for in public institutions.

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E. S. Loizeaux, M. D. (San Diego County General Hospital, San Diego).—There is little question that the care of the chronically ill, the infirm, and the aged have a distinct place and responsibility in our social scheme. The paper is most refreshing in view of the occasional reappearance of that old barbaric discussion under the term of "euthanasia." We, of California, perhaps are to such an extent particularly imbued with the joy and practice of living that we have attracted to us, in addition to others, the thwarted, the homeless, the wandering, and the infirm, some with their families. These groups necessarily fall on municipal or community care, particularly in sickness, and very frequently before even that arises. Advancing years make the situation more confirmed, readily accounting for the 85 per cent in Table 5. Two small very readable books closely allied to this subject deal encouragement and help to those who, through the efforts to solve this question, find their paths winding. I speak of Dr. Frederic Peterson's "Creative Reëducation" and Dr. Alfred Worcester's "The Care of the Aged, the Dying, and the Dead."

Regarding institutional care it would seem that those amenable to reëducation should properly be separated from the mentally infirm and aged, and that considerable group, who, although still living and breathing and even ambulatory, have achieved a sort of physical nirvana. The desirability of separating these groups from the acutely sick is undebatable, and the segregation of the tuberculous is also beyond discussion. In many instances where domiciliary care alone is required, the social worker should be at his or her best in deciding a useful spot for the same, and should carry them along with the knowledge that, whereas many do well under the management of institutional care, they do poorly without such control. These should be recognized after carefully supervised trial and permanently institutionalized.

There has developed in this community a group of nursing homes which are under license and subject to supervision. They carry the chronic, infirm, and some convalescent cases in a very efficient manner, many times serving

the double purpose of self-support and individualized care which, in certain cases, is very desirable, particularly for those who have not been able to adjust themselves to the drastic change in social status that may have been their lot. This, with old-age security, keeps the county home at a perceptibly lower census.

In closing these remarks, I cannot refrain from mentioning our present view of these charges. They were formerly "indigents," "dependent poor," or "paupers." We find ourselves now referring to them as "patients" in the public hospitals, "clients" of welfare, and "guests" at the county farm or home. Even the latter is softened by leaving out the word "county" and calling it "Edgemoor," "Laguna Honda," or "Fairmont," as the location may be.

Work, as has been portrayed at Laguna Honda, is a splendid feature in reconstruction and well worthy of organized extension such as is done with the blind and others. In speaking of work, Gibran makes "The Prophet" say: "And if you cannot work with love but only with distaste, it is better that you should leave your work and sit at the gate to take alms of those who work with joy."

TUBERCULOSIS IN SAN QUENTIN*

By Leo L. Stanley, M. D.
San Quentin

FAIRLY complete records have been left regarding health conditions in San Quentin Prison since its establishment in 1851.

The care and treatment of tuberculosis presented a great problem in the early days; but the records speak for themselves.

1854: POPULATION, 236

The prison was first established in 1851 at Point San Quentin. The prisoners were leased to a contractor and were occupied in making brick. J. M. Estell, the lessee, in speaking of general conditions at that time, stated that "dense fogs prevailed for five months in the year. Heavy winds lift dense fogs over the summit of Mount Tamalpais and precipitate them, without notice, on the eastern slope, rendering it impossible to distinguish an object at a few yards. It frequently happens that several days will elapse without the possibility of taking the prisoners from their cells in consequence. On one occasion the prisoners passed an entire week in their cells without being able to go even to their meals, fog being so dense." A legislative committee reported that "the general clothing of the prisoners seemed too scant for winter weather, the most of which clothing appears to be the last remains of what was worn there by them, now in such a tattered, torn, forbidding and filthy condition that the common street beggars would have appearance by comparison of a newly Parisian-clad gentleman. The bedding seemed to be insufficient to protect them from absolute suffering from cold. They have one coarse, shaggy, double blanket, but some lack even this, and they are compelled to sleep with their day clothes on, shoes and all (if they chance to have them). In the so-called 'long room,' prisoners are turned loose like so many brute animals in a corral to stay and sleep, the young, middle-aged, and old. The manner of stowing away such a number in so small a space is accomplished by standing bunks close to each other. The stench ensuing from the room when opened in the morning would have to be imagined, as description is impossible."

1858: POPULATION, 582

In this year Dr. A. W. Taliaferro, as resident physician, reported to the warden: "As you know, the men when locked up are literally piled one upon another. This fills the room with animal heat and impure air. The mornings are cold and chilly when the men are called out to work. Sudden transition from heat to cold, with their bodies much relaxed and debilitated by the heat and impure air of the rooms, renders them very susceptible to pulmonary diseases." Of the 374 cases treated during this year, 150 were for influenza, seven for pleurisy, three for pneumonia, and three for phthisis pulmonis.

1863: POPULATION, 551

In this year Dr. J. B. D. Stillman was appointed visiting physician by Leland Stanford, president of the State Prison Directors. Doctor Stillman was a father of the late Stanley Stillman and J. M. Stillman, both professors of Stanford University. He stated that "phthisis carries off the greatest number of all those who die from natural causes. The Indian race suffers particularly from this cause, as they appear to do wherever they are subject to confinement. Of the seven deaths from tuberculosis disease during the previous two years, six have fallen upon Indians."

1868: POPULATION, 711

"An examination of mortuary reports shows that most of the diseases occur from consumption and are confined mostly to the Indian race. It is worthy of remark here that the Indian race is particularly prone to scrofula and scrofulous consumption when brought to this place. Free as the air when upon his native heath of all hereditary disease, here he soon falls victim to those ills flesh is heir to, and sentence to this place is almost a sure doom for life."

1873: POPULATION, 916

Dr. P. E. Randle, reporting to Lieutenant Governor Pacheco, stated that "a large portion of the convicts sent to the prison are afflicted with chronic diseases upon their arrival, such as syphilis, phthisis, and scrofula. These diseases are generally contracted previous to arrest and aggravated by confinement. Some do not recuperate sufficiently to be able to perform ordinary labor for weeks and months, and some never recover, but linger awhile and die from exhaustion and delapidated constitution. We have four rooms with forty-five men in each, and one-half, if not more of them, are afflicted with various maladies. They are locked up for thirteen to fourteen hours out of the twenty-four, sleeping and existing in a fetid and illy ventilated atmosphere made absolutely poisonous by exhalations from diseased lungs and unwashed surfaces, and effluvia arising from accumulations of excrementitious matter deposited in a common receptacle during all these hours." In February, 1876, fire destroyed the principal workshops, including quarters for nearly one hundred prisoners. Prison rules

* Read before the General Medicine Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

adopted confined to the prison quarters all convicts not engaged in some employment or occupation, which resulted in the locking up of over five hundred persons each day, twenty-four hours of the twenty-four."

1879: POPULATION, 1525

At this time only three hundred prisoners were employed by contractors in the shops, making furniture and sash-and-door products. As a result, over five hundred had to be kept in confinement. A limited number at a time were let out for exercise. Causes of death for this period, at which time the rate was seventeen per thousand, were attributed to congestion of the lungs, phthisis pulmonis, chronic bronchitis, bronchial consumption and pulmonary gangrene. Dr. J. E. Pelham, surgeon, remarked that "there has been an increase in the number of chest diseases." "As a rule, in these cases," he remarks: "The subject visits me suffering from a cold, more or less severe, affecting the air passages. The same cause of disease still operating, the patient may present himself with chronic inflammation of the larynx, pharynx, or trachea, which by easy grades passes to chronic bronchitis and finally terminates in bronchial consumption. The remedy for this state of affairs would be the confinement of the prisoners in their cells until a later hour in the morning."

1880: POPULATION, 1500

The new prison at Folsom was opened at this time, and two hundred prisoners were sent from San Quentin. Of these two hundred, Dr. W. W. Grover, surgeon at Folsom, reported, "over 30 per cent were suffering from chronic or organic disease which, together with long confinement and vicious habits, have so enfeebled them that they are unable to perform any laborious work, and are subject to constant and daily medical treatment." A jute mill was established at San Quentin in 1881 with one hundred looms.

1883: POPULATION, 1191

Dr. N. J. Bird reported that "we have nearly twelve hundred prisoners, of whom about one-third are either totally or partially disabled—some scarcely able to walk through the gates on their arrival here." At this time there were thirteen deaths, seven from phthisis pulmonis, one from scrofula, two from emphysema of the lungs, and one from pneumonia. The doctor remarks that "although there were an unusually large number of deaths during this year, yet, when we take into consideration the history of the patients and the character of their diseases, the wonder is not that so many died, but that so many lived so long."

1885: POPULATION, 1180

A two-story brick hospital, costing $8,000, was constructed at San Quentin, but "during that year," wrote Dr. T. B. Eagle, "we have had a high death rate, the greatest number of cases of mortality resulting from that dread disease, consumption. Of a total of twenty-nine deaths, eighteen died of pulmonary disease and three of scrofula." Light upon

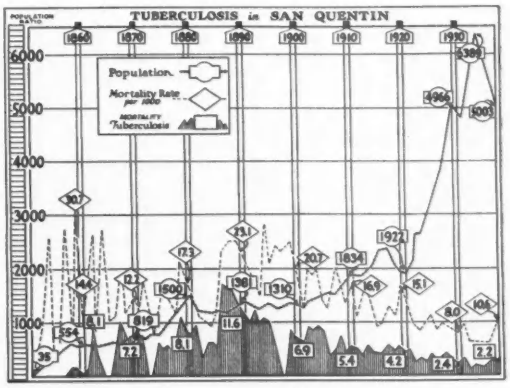

Fig. 1

the increased mortality and morbidity of prison at this time is cast by the observation of the resident physician that "our new improved hospital facilities are known to most of the courts of the state, and in consequence our chronic and invalid population has largely augmented." Chaplain W. H. Hill noted, among other things, that he attended thirty-one funerals.

1888: POPULATION, 1277

Dr. F. C. Durant, then writing about Indians and Mexicans, said that "they stood imprisonment very illy. More than half of the hospital admissions were from these two classes. Very soon after coming in they break out with scrofulous or syphilitic sores, which, on treatment, mend, and then attack the lungs and they die of phthisis." During this year, on account of the increased demand for jute bags, it became necessary to enlarge the jute mill and work a day-and-night shift.

In 1889 Doctor Durant again observed the tuberculosis situation in the following words: ". . . I desire to call your attention to the unusual number of deaths from consumption—seventeen, half of the whole number of deaths, from this fell scourge. Nearly all came here with the disease perfectly developed and easily distinguishable. I now have five men in the hospital who will eventually die with this awful disease, whose lives could have been prolonged could they have been sent to a more salubrious climate.

"Therefore, I am in hearty accord with Doctor Ruggles of the State Board of Health when he proposes to have the Board issue a circular addressed to all judges asking them to carefully examine (or have the county physician do so) all prisoners, and have them send those who have the slightest lung trouble to Folsom, for this reason: that the increased dryness of the air at that place is greatly to the advantage of all who suffer from lung troubles, more particularly consumption and asthma.

"It is well known that the Bay climate is the worst possible for those troubles; therefore, for the sake of extending the life of those suffering from those troubles, and for the better preservation of the health of the convict, it would be only humane to send all who show the slightest disease of the lungs to Folsom.

"Another thing is the great number of Spaniards who develop this disease. After being confined here for a few weeks, they commence coughing and rapidly go down, are taken to the hospital, and eventually die in spite of all medication.

"The jute mill seems to be the worst place for them, and I am very careful to take them out of the mill when my attention is first called to them and put them in the road gang, where they sometimes pick up, but in nearly every case the relief is but temporary, and they soon sicken and die.

"Taking data from these facts, I would most strongly urge upon the Board of Directors to cooperate with the Board of Health, and call upon the different judges to send all who are so afflicted to Folsom. . . . The death rate continues to be somewhat large. This is owing to the large per cent of Spaniards, Indians and Chinamen who, from the very nature of things, are prone to develop consumption, scrofula, and other kindred diseases."

1890: POPULATION, 1381

The report of the doctor for the following year, 1890, is somewhat encouraging. "While the death rate is smaller than last year, yet it has not kept within my expectations, being but two less than the previous year. This was due to the very severe weather we had in January, when the whole country was suffering from the 'grippe'; the men, while not dying from the 'grippe,' were so affected by it that they never recovered; this, particularly among men who were troubled with lung difficulties. Thus, we had ten deaths in April, which was an unusual number; but you will see by the tables that this occurred among the phthisical patients almost entirely."

But in reply to this note, the report of Doctor Eagle of Folsom: "I desire to take issue with the effort that is being made in certain quarters tending to establish at this prison a 'sanitarium' or 'lying-in asylum' for all the broken down phthisical criminals of the State. I will admit that the climate here is all that can be said for it, so far as its benefits are concerned to the consumptive, the rheumatic, and the syphilitic; but so long as the present sanitary conditions here obtain, and until our narrow and limited hospital accommodations are enlarged, it would not be only unwise and inhuman, but exceedingly detrimental to the interests and health of this institution, to foist upon it the burden and care of the *bacillus-bearing* criminal to propagate and spread disease and death in our little community. To treat tuberculosis successfully, strict isolation must be resorted to, and the most stringent aseptic conditions observed in order to insure favorable results."

"In 1894 the death rate at Folsom was comparatively low. And this in the face of the fact that the courts continued their beneficent efforts in sending the consumptive criminals to Folsom to die. In nearly every case must this advice have been heeded, for we have been taxed to the utmost with the care and treatment of more diseased and debilitated humanity than any other like institution in the country."

1895: POPULATION, 1278

Dr. I. L. R. Mansfield, resident physician, reported to Warden Hale of San Quentin that "phthisis pulmonis has been, as heretofore, the principal cause of death. In nearly every instance, however, those who have died from this cause contracted the disease prior to their admission to the prison, and several were in the last stages when they entered the institution."

1902: POPULATION, 1407

Governor George C. Pardee was informed that "the California prisons are conducted on what is known as the congregate system, and nearly all the evils which our prisoners suffer are traceable to prison management. In San Quentin, we have nearly fifteen hundred convicts and only six hundred cells, necessitating the placing of five and six convicts in one cell, and, in one instance, forty-five in one of the larger rooms."

1904: POPULATION, 1495

Prisoners crowded together in this manner have ample opportunity to plot and scheme, and even commit felonies without detection. When inmates are in the upper yard, where they are forced to congregate on holidays and Sundays, the limited space makes it almost impossible for them to move about, much less obtain the exercise the physical condition of many of them demands.

Dr. P. F. Casey states that "the death rate from all causes has been small considering the population handled, being only thirty, including executions, in a population of over two thousand." He called attention to the large percentage of diseases of respiratory organs, about 50 per cent of the deaths that occurred having been from tuberculosis. Bad ventilation of the jute mill caused the air to be full of fine particles of dust, which injure the air passages, leaving a fertile field for the tubercle bacillus.

From 1904 to 1913 little was done for the betterment of the health of the inmates, although from 1909 on, an effort was made to perform necessary surgical operations. This was accomplished for the most part by visiting physicians, who rendered their services gratuitously. The surgical equipment was very crude, and comparatively little was done.

1913: POPULATION, 1910

My personal experience with San Quentin began in February, 1913, at which time I was appointed assistant resident physician.

At this time there were about twenty patients with active tuberculosis, treated, or rather, housed, in two small rooms on the top floor of the so-called "Old Hospital," which was built in 1859. The ventilation was abominable, the beds were crowded together, air space was extremely limited, a few old-fashioned windows, low and narrow, let in a very little light. The walls were of a dark hue, making the rooms cheerless and foreboding. Whites, Negroes, and Indians commingled here indiscriminately. The surroundings were extremely sordid. Here, crowded in abject misery, lacking the essentials for cure—light and air—were these diseased

prisoners, coughing, and too enfeebled for the most part, to leave their beds. To add to their discomfort, a dilapidated toilet and unsanitary bath were screened off in one corner by a shell of a partition, while in the center of the room a coal stove gave those men who were able the opportunity to cook the rations of eggs, or other food, they were allotted.

After my appointment as resident physician in August, 1913, free hand was given in hospital management and improvements. James A. Johnson, present warden at Alcatraz, became the warden at San Quentin in the same year. He understood the problem well and gave unbounded aid to the improvement of sanitary conditions.

Tuberculosis was the first problem attacked as its importance was greatest. A modern, open-air tuberculosis hospital was built on the flat roofs of three adjoining buildings. It covered forty-eight hundred square feet and was arranged in the form of two adjacent quadrangles with concrete floor and courts in the center. Surrounding these courts were sheltered wards enclosed by sliding windows on the outside and French doors on the inside. Every prisoner who showed any signs at all of tuberculosis was placed in this hospital. A system of physical examination on entrance was made, and in this way many cases which otherwise would not have been recognized were discovered and immediately hospitalized. A number of specialists, including Drs. G. R. Hubbell, now deceased, R. A. Peers, L. S. Mace and others, kindly offered their advice and suggestions for the care and treatment of these prisoners.

1915: POPULATION, 2286

Because of the good facilities for caring for tuberculosis at San Quentin, the Board of Prison Directors decided to send all afflicted prisoners from Folsom to this place for care and treatment. About forty were transferred during the following three years. The standard treatment of tuberculosis was employed, as were numerous additions such as pneumothorax, phrenicotomy, chest collapse, and other means of treatment.

1934: POPULATION, 6400

This year showed the peak of prison population making San Quentin Prison the largest penal institution in the world. An entirely new hospital was completed at this time. The fourth floor was converted into an open air tuberculosis hospital for the treatment of tuberculosis patients. At this time, with the population over six thousand, the number of tuberculosis patients was about forty, whereas in 1913, with a prison population of 1910, the number of patients afflicted with tuberculosis was over sixty.

1938: POPULATION, 5122

In addition to the very complete physical examination given to all prisoners entering San Quentin, an x-ray is taken of each man's chest. All patients are immediately hospitalized, if evidence of tuberculosis is found. The fact that in 1886 seventeen per thousand died of tuberculosis, and in 1937 only two per thousand, shows the general improvement in the treatment of this disease.

Medical Department, California State Prison.

REGIONAL ANESTHESIA AND THE ACUTE ABDOMEN*

By E. C. Moore, M. D.
Los Angeles

Discussion *by Thomas O. Burger, M. D., San Diego; Alanson Weeks, M. D., and G. D. Delprat, M. D., San Francisco.*

THE success or failure of any surgical procedure advocated for daily use must rest upon the clinical results obtained. The varying physical and psychic factors encountered in each patient make it impractical to handle all cases successfully in a routine manner. The selection of the anesthetic agent and method for each patient should be given the same consideration as the type of operation contemplated. In making this selection the safety and comfort of the patient, during and after the surgical procedure, must be given first consideration.

One of the primary requisites of good surgery is adequate exposure. This can best be obtained without unnecessary trauma when complete muscular relaxation is present. For practical purposes we have three types of regional block that are of value in abdominal surgery. These may be used alone or combined with light gas anesthesia, preferably cyclopropane, because of its potency and the high percentage of oxygen with which it can be used. The three procedures are subarachnoid block, peridural block, and abdominal field block.

One of the greatest handicaps regional anesthesia has had to overcome has been the enthusiastic adherents of its use who could see nothing good in any form of general anesthesia. On the other hand, many of the adherents of general anesthesia have been unable to convince themselves that regional anesthesia is of any benefit to the patient. The work of Crile and his theory of *anoci association* (?) is well established. With this in mind, we have tried to develop a satisfactory technique in handling our abdominal surgery which we feel offers the patient the greatest margin of safety during and after the operation.

In carrying out our regional procedures we do not object to those patients who desire it being asleep during the operative procedure. They are practically all willing to have a preliminary block when it is explained to them they can go to sleep before the operation is started. For upper abdominal work we prefer a combination of regional and general anesthesia, because of the nausea and discomfort that is practically always produced when traction is made on the liver or stomach.

PREOPERATIVE PREPARATION

Much can be done toward reducing the postoperative morbidity by proper preparation of the patient for surgery. In addition to the use of sufficient preliminary medication in the form of hypnotics and narcotics, it is frequently of benefit to give intravenous injections of glucose or normal saline, as may be indicated. Excessive or persistent

* Read before the General Surgery Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

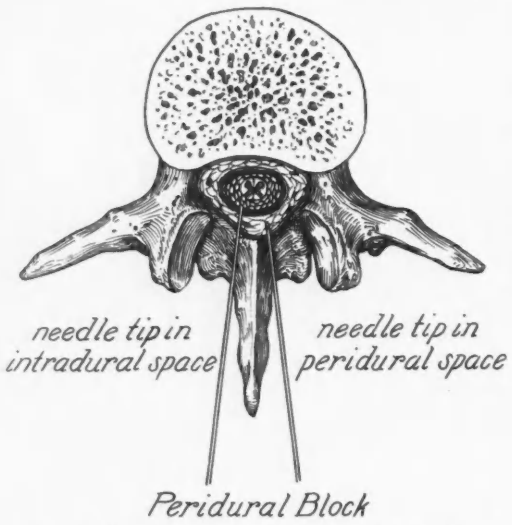

Fig. 1.—Peridural Block (after Odom, Am. J. Surg., December, 1936).

vomiting will usually produce an acidosis that will be greatly benefited by the administration of glucose. High intestinal obstruction will produce an alkalosis, with a reduction of the blood chlorids and an elevation of nonprotein nitrogen. This is benefited by intravenous injection of normal saline.* Careful attention to such details will prove of material aid in preventing or minimizing surgical shock.

PERIDURAL ANESTHESIA

Since the primary function of the blood is to carry oxygen to the tissues in the presence of a hemoglobin of less than seventy, any anesthetic that diminishes the oxygen supply may be unduly hazardous. Thalhimer states that "the administration of any of our usual inhalation anesthetics for a very short period may produce marked changes in the oxygen-carrying power of the blood, in addition to alterations in the erythrocyte count and hemoglobin content." High spinal anesthesia may reduce the tidal exchange by as much as 60 per cent due to paralysis of the muscles of respiration. This reduction is not so great with peridural block and can be more easily compensated by the administration of oxygen. For this reason, in the presence of a low hemoglobin we frequently chose peridural anesthesia in preference to spinal. Peridural anesthesia was first suggested by Corning about 1885. He did some caudals and then, instead of carrying out his original idea, became sidetracked on subarachnoid block. Fidel Pages in 1920 did some work on peridural and published his results. Soon thereafter he developed pneumonia and died, and the work he had started was not carried on. Dogliotti in the late twenties became interested in this type of anesthesia without having read of Page's work, and it is due to his efforts that this form of block has again been called to our attention.

* Thalhimer W. Laboratory aids in preparation and after care of surgical patients. Anes. and Anal., 7:30-33, (January) 1928.

Peridural anesthesia is similar in principle to caudal anesthesia. The anesthesia obtained is similar, and in reality is a bilateral paravertebral block. The epidural space extends from the foramen magnum to the sacral hiatus. The dura is continued as a covering for the spinal nerves which emerge through it until the nerves leave the intervertebral foramina. By injecting novocain into the peridural space it is possible to obtain a segmental anesthesia by the novocain making contact with the nerves outside the vertebral canal beyond the point they are protected by the dura. The muscular relaxation obtained with peridural block approximates that obtained with spinal anesthesia, and the danger of respiratory paralysis is eliminated, as it is impossible for the solution to reach the respiratory center.

For upper abdominal surgery, with the exception of perforated ulcers, a combination of peridural anesthesia and gas has proved most satisfactory. When this combined anesthesia is used, twenty-five cubic centimeters of 2 per cent novocain is injected, and the head of the table is lowered while the patient is being prepared for surgery. Cyclopropane is started immediately, and usually by the time the peritoneum is reached the injection has produced sufficient relaxation so that a very light stage of general anesthesia is sufficient. This eliminates much waste time, as the operation is started as soon as the patient can be prepared after the completion of the injection. Perforated ulcers do not need be combined with gas, as there is usually very little traction and pulling on the stomach.

ABDOMINAL FIELD BLOCK

The peritoneum of the anterior and posterior abdominal wall and the diaphragm, as far as it is supplied by spinal nerves, is sensitive to pain. The visceral peritoneum of the stomach, intestines, gall bladder, and liver does not possess sensory nerves reacting to the usual mechanical and thermic irritation, for the production of pain, touch, warmth and cold. These parts can then be crushed, cut or burned, without pain. Traction on the stomach, gall bladder or liver does cause pain. Ligation or clamping of the mesenteric vessels causes pain of varying degrees, depending on the sensitivity of the individual.†

† Local Anesthesia, Braun Shields, page 36.

TABLE 1.—*Regional Anesthesia and the Acute Abdomen*

	No. Cases	Hospital Deaths
Appendicitis, acute	21	..
Intestinal obstruction, acute		
Due to bands	9	1
Due to carcinoma	3	..
Due to pelvic abscess	1	..
Empyema of gall-bladder	5	..
Duodenal ulcer, acute perforated	1	..
Gunshot diaphragm, liver, spleen	1	..
Carcinoma Colon, Acute Perforated	1	..
Total	42	1

The usefulness of abdominal field block in view of this nerve supply is evidently quite limited. For the patient who is critically ill, or in extremis, on whom an abdominal exploration is indicated, it is of value. There is less danger of an untoward novocain reaction than with spinal or peridural anesthesia. If upon opening the abdomen an extensive operation is indicated, the novocain will furnish the necessary muscular relaxation, and a light stage of general anesthesia can be maintained to prevent any discomfort from the necessary traction and pulling on the abdominal viscera. This entire block will require from 100 to 150 cubic centimeters of 0.5 per cent novocain, and will produce complete anesthesia of the abdominal wall and peritoneum inside the area injected.

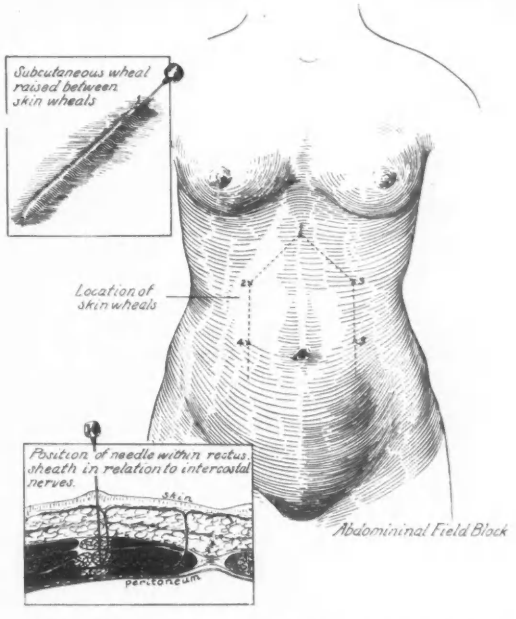

Fig. 2.—Abdominal field block (after Labat, "Regional Anesthesia").

SPINAL ANESTHESIA

Reliable statistics indicate a mortality of from 1:1000 to 1:1100 in spinal anesthesia. We feel the reduction in surgical trauma and shock warrants assuming this increased anesthetic risk when spinal anesthesia is indicated. Indeed, it would be poor policy, as Sise states,‡ to save a fraction of 1 per cent anesthetic mortality, if this small saving entails an increase in surgical mortality of 1 per cent or more.

EXPOSURE IN ABDOMINAL SURGERY

It has often been stated that exposure is everything in abdominal surgery. This, of course, is a too all-inclusive statement, as there are many other factors in the pre- and postoperative care that lend their influence to the outcome of a given case. However, in acute intra-abdominal lesions requiring emergency surgery, nothing is so comforting to the operator as is the knowledge that his work is being done under direct vision, with a minimum of "blind dissection" as a result of bulky packs, bulging intestines, or semirelaxed muscles in the abdominal wall. With good exposure, a novice may succeed, where, if such an ideal situation were lacking, an expert may fail.

CRITERIA IN SURGICAL TECHNIQUE

In surgical technique as related to the acute abdomen, we subconsciously bear in mind certain criteria for successful treatment of the immediate lesion, and for the prevention of complications and sequelae. Every move and act is directed toward the achievement of these criteria. With satisfactory exposure, attained without trauma, such may be accomplished with comparative ease. Correction of the causative lesion is naturally of prime importance. Adequate hemostasis as an assurance against secondary hemorrhage is next uppermost in our minds. The prevention of peritonitis and, if already present, its spread, are definite obstacles to overcome in the surgery of many acute abdominal conditions. Dilated intestinal loops, as seen under general anesthesia with its associated respiratory heaving, materially contribute to the spread of infection. The occasional need of vigorous packing, for this reason, additionally lays the foundation for future bands and adhesions in the susceptible patient. Similarly, the pull of retractors in an attempt to overcome partially relaxed recti muscles injures the endothelial lining of the peritoneum, thus inviting future adherence to adjacent intestinal loops. Suture of the incision, particularly in the upper abdomen, may be a most difficult procedure in the presence of rigid recti muscles and respiratory heaving. Small transverse tears in the posterior sheath and peritoneum are often the forerunners of a wound disruption, requiring secondary closure with its added mortality rate; or possibly a deep wound separation, and later an embarrassing incisional hernia which another surgeon will probably repair.

Aids to good exposure, in addition to an adequate incision, include (1) muscular relaxation, (2) quiet respiration, and (3) a quiet gastrointestinal tract. These may all be had when spinal anesthesia or peridural block, either alone or in combination with light gas anesthesia, are administered by a skilled anesthetist, who is in constant attendance and may anticipate and forestall any untoward reactions. Few authorities refute the fact that relaxation is eminently more satisfactory in regional anesthesia. Uniform quiet respiration is the rule, and all of you have no doubt had occasion to compare the compact, contracted intestinal tract under spinal anesthesia with the toneless, air-filled loops of bowel which, under general anesthesia, annoyingly obstruct our line of vision and retreat only as a result of forced packing.

CLINICAL MATERIAL

In a gunshot case we were especially appreciative of the type of anesthesia, as it was necessary to repair a rent in the left dome of the diaphragm in addition to splenectomy, closure of stomach perforations, and packing a badly lacerated liver.

‡ Sise, L. F.: Choice of Anesthesia for Surgery of the Upper Abdomen, Amer. Jour. Surg., page 22, (April) 1938.

Of 1406 abdominal cases operated upon in the past three years, 147 were acute, requiring emergency surgery. In forty-two of this number, it was elected to administer some form of regional anesthesia.

It was noted that these patients were quiet and cooperative upon their return from the operating room. They perspired but little, thus conserving body fluids and decreasing the danger of chilling. Convalescence was usually smooth, with less tendency toward nausea and vomiting. Tympanitis appeared less frequent.

There were no complications, except for one hospital death. This occurred in an advanced intestinal obstruction of several days' duration, in which enterostomy was done. Three other patients died later at home. All of these were the result of inoperable carcinoma producing intestinal obstruction for which palliative procedures only were performed. Death occurred at six months, three months, and six weeks postoperative.

The judicial use of spinal or regional anesthesia has proved so satisfying in the acute abdomen that we extended its scope to include more and more elective cases. Indeed, during the past year general anesthesia was administered only to the occasional patient presenting an abdominal lesion.

SUMMARY AND CONCLUSIONS

1. In the absence of contraindications as regards age or the general condition of the patient, we believe some form of regional anesthesia, either alone or in combination with light gas, to be the anesthetic of choice in surgery of the acute abdomen.

2. Three types of regional block are of practical value in abdominal surgery. They are (1) subarachnoid block, (2) peridural block, and (3) abdominal field block.

3. Affording good exposure with a minimum of trauma due to retraction and packing, it renders more certain a smooth operation, and uneventful convalescence, and a lack of future sequelae.

511 South Bonnie Brae.

DISCUSSION

THOMAS O. BURGER, M. D. (2120 Fourth Avenue, San Diego).—Probably no part of a major operation is more important, as Doctor Moore so well points out, than the anesthetic. I emphatically agree with Doctor Moore that the choice of anesthetic must be as carefully individualized as any other part of the operation, if the patient's welfare is to be best served. In my practice I have been using spinal anesthesia increasingly for more than twelve years. During the past six or eight years subarachnoid block has become more and more the anesthetic of choice, particularly for work in the lower abdomen and pelvis.

Acute appendicitis and intestinal obstruction are diseases in which I feel that spinal anesthesia is almost mandatory, if the patient's condition does not otherwise contra-indicate. It is in these diseases, particularly, that collapse of the intestine and very quiet breathing (which this form of anesthesia promotes), are in such marked and favorable contrasts to the distended gut, heaving diaphragm, and rigid abdominal muscles which so trouble one when a general anesthetic is used. As any surgeon of experience knows, appendectomy is frequently as difficult an operation as one is called upon to perform. Pain and point-tenderness demonstrated in the right lower quadrant is no guarantee whatever that the appendix will be found lying free and easily available when the incision is made through the belly wall. As was pointed out in our study of a ten-year series of cases of acute appendicitis presented at this meeting, the appendix, in a good third of the cases, is retrocecal, pelvic, or presents some difficulty in its removal. It is in these difficult cases that the exposure afforded by subarachnoid block is so valuable; not to have to fight the mass of distended gut with packing and evisceration lessens shock and decreases the chance of spreading possible infection through the coils of the intestine, that are traumatized by packing or an unavoidable leak in removing a difficultly distended appendix.

Our series of spinals now numbers well over three thousand, with only one fatality. This occurred early in our use of the method, and we are quite convinced that the accident could have been avoided with our present technique. Although I have at hand no detailed figures, I am sure that the incidence of postoperative complications, particularly of the respiratory tract and infection, are distinctly less following spinal than after any form of inhalational anesthesia, including the newer gases. The only reactions which we have been able to attribute to the use of this form of anesthesia is a moderate fall in blood pressure, and mild-to-moderate nausea toward the close of the operation. This usually occurs only when peritoneum is put under tension. In no case in the past half-dozen years has the blood pressure of a patient fallen low enough to cause us alarm. The drop in pressure can usually be controlled by the timely administration of ephedrin.

The surgeon should not overlook the occasional value, as pointed out by Doctor Moore, of the use of regional field block. The patient whose vascular system is sclerotic, whose lungs are emphysematous, and whose blood pressure is perhaps markedly elevated, is a poor candidate for subarachnoid block. He is also a notably poor subject for general anesthesia, but if a surgical procedure in the abdomen is urgent, he will often do well with a local block supplemented, perhaps, as Doctor Moore suggests, with a minimum of one of the modern gases.

I do not believe that the direct mortality of spinal is greater when properly given and observed than any other anesthetic. In my own mind I am convinced that with the advantages enumerated above, fewer deaths will result following acute abdominal surgery than with any other type of anesthesia.

*

ALANSON WEEKS, M. D., and G. D. DELPRAT, M. D. (384 Post Street, San Francisco).—Doctor Moore's presentation of regional anesthesia leaves little to add. He presents a series of 147 patients with acute abdominal conditions, of which forty-two were treated with some form of regional anesthesia. His description of the excellent character of the anesthesia leads one to ask why it was not used on more cases? There is, of course, no question but that spinal anesthesia, even for upper abdominal conditions, gives a type of relaxation that makes the operative procedure most comfortable for the surgeon. If the patient dislikes hearing the operating room noises, these can be eliminated by very light inhalation-gas anesthesia, which in itself would be quite inadequate for the relaxation otherwise obtained. We have long been convinced that the incidence of postoperative accidents, such as pneumonia, atelectasis, phlebitis, etc., is independent of the anesthetic agent. We have seen as many postoperative pneumonias, and acute collapse of the lung, develop in patients who were operated under novocaine anesthesia alone, as we have among those who were given ether inhalation. Apparently the question is not so much one of irritation of the bronchial tree as it is the later pain in the incision inhibiting the cough reflex in those patients who develop pulmonary complications. A definite factor that must be reckoned with in spinal anesthesia, however, is uncontrolled and unexpected persistent headache.

It has been our pratice to use local novocaine infiltration exclusively for the surgical repair of hernia. This, in a patient with a moderate preoperative medication, gives an excellent relaxation. This anesthesia, combined with the Joyce technique of repair, makes an inguinal hernioplasty as simple as the so-called injection method, and is, in our opinion, a thousand times more desirable.

GOITER: ITS CLINICAL MANAGEMENT*

By Mayo H. Soley, M.D.
San Francisco

Discussion *by H. Glenn Bell, M.D., San Francisco; Leon Goldman, M.D., San Francisco.*

THE geographical location of San Francisco, together with the advances in surgery of the thyroid gland made under the leadership of Dr. Wallace I. Terry, have been responsible for the growing thyroid clinic at the University of California Hospital. In the period of two years, from July 1, 1935 to June 20, 1937, we have had 212 patients who required thyroidectomy or x-ray treatment for goiter of various types. Thirty-seven hundred other patients were seen from 1912 to 1935. Our experience in handling these patients, and the opinions of leading students of diseases of the thyroid in this country, form the basis of the statements made in this paper.

CLASSIFICATION

In recent years the classification of goiter as given in Table 1 has been used in our thyroid clinic: This classification allows subdivisions which can include all the variations seen clinically. For example, in the group of nontoxic nodular goiter, such conditions may be included as degeneration, hemorrhage, calcification, tracheal displacement, recurrent laryngeal paresis or paralysis, and substernal or subclavicular extension. It should be stressed that the term "nodular goiter" is only a descriptive clinical diagnosis, and in no way identifies the pathological condition of the enlarged thyroid. The classifications of "toxic diffuse" and "toxic nodular" goiter have the advantage of including the intermediate types of toxic goiter (that is, intermediate between the syndrome of Graves [1] and that of Plummer [2]), in which a nodular goiter is accompanied by hyperthyroidism and exophthalmos.

* From the Department of Medicine of the University of California Medical School, San Francisco.

Read before the General Medicine Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

Table 1.—*Classification of Thyroid Disease*

1. Nontoxic diffuse goiter
   (Simple, endemic, colloid or iodin-deficiency goiter)
2. Nontoxic nodular goiter
3. Toxic goiter
   - Toxic diffuse goiter (exophthalmic goiter; Graves's, Parry's or Basedow's disease)
   - Toxic nodular goiter
     - Hyperthyroidism with coincident nodular goiter
     - Hyperthyroidism with pre-existing nodular goiter
4. Thyroiditis
   - Acute thyroiditis with or without suppuration
   - Chronic thyroiditis
     - Hashimoto's struma
     - Riedel's struma
5. Neoplasms of the thyroid
   - Benign
     - Papillary adenomas
     - ? Fetal adenomas
   - Malignant
     - Carcinomata
     - Lymphosarcomata
     - Sarcomata
6. Anomalies of the thyroid
   - Thyroglossal tract remnants
   - Aberrant thyroid tissue
7. Hypothyroid states
   - Cretinism
   - Juvenile myxedema
   - Adult myxedema
   - Cachexia strumipriva
   - Hypothyroidism

Table 2.—*Relative Incidence of Types of Thyroid Disease in Boston and San Francisco*

	University of California Hospital July 1, 1935, to June 30, 1937		M.G.H. 1927-1936*
Surgically treated:	Number of Cases	Per Cent of Total	Per Cent
Nontoxic diffuse goiter	1	0.47	
Nontoxic nodular goiter	78	36.79	32.5
Toxic goiter Diffuse 63 cases, 29.71 per cent Nodular 26 cases, 12.26 per cent	89	41.98	32.7
Thyroiditis	8	3.77	1.1
Carcinoma	6	2.83	1.7
Treated with x-ray			
Toxic goiter Diffuse 26 cases, 12.26 per cent Nodular 4 cases, 1.88 per cent	30	14.15	
Total	212	99.99	

* From James H. Means: Thyroid and Its Diseases. J. P. Lippincott Company, Philadelphia, 1937.

Table 2 gives the relative incidence of the various types of goiter seen in our clinic, and in the clinic of Dr. James H. Means at the Massachusetts General Hospital in Boston. The only significant differences in the percentages are accounted for by the facts that we have not included patients with simple goiter, and that we have had more cases of thyroiditis and carcinoma.

NONTOXIC DIFFUSE GOITER

Nontoxic diffuse goiter (simple or colloid goiter) is seen not infrequently in San Francisco, although this is not an endemic region. In adolescents, small doses of iodin often reduce the size of the thyroid, and certainly eliminate the iodin deficiency which caused the initial enlargement. It has been estimated that the daily iodin requirement is from 20 [3] to 75 [4] gammas, and is greater in adolescence and during pregnancy. Since one drop of Lugol's solution (Liquor Iodi Compositus, U. S. P.) contains 7.8 milligrams of iodin, a single drop of iodin a week should suffice as prophylaxis or treatment. In this country the danger of causing "Iod-Basedow" has been exaggerated, but a dose of one drop of Lugol's solution per week should not worry even those clinicians who feel that this condition is a common one. Since iodized salt is rather generally used in California, the iodin deficiency producing the majority of endemic goiters must be relative rather than absolute. If small doses of

TABLE 3.—*X-ray Therapy of Hyperthyroidism*

Thyroid Clinic, University of California Hospital
July 1, 1935, to June 30, 1937

	Number of Cases	Total Number of Cases
Toxic diffuse goiter:		
Patients treated (7 of these for postoperative recurrences)		26
Hyperthyroidism "cured"	17	
Status questionable (inadequate follow-up)	3	
Persistent hyperthyroidism	1	
Recurrence	1	
Patients subsequently operated on	4	
Reasons:		
X-ray burn	1	
Domestic conditions	1	
Recurrence	1	
Intentionally treated preoperatively	1	
Toxic nodular goiter:		
Patients treated		4
Hyperthyroidism "cured"	3	
Minimal but definite residual symptoms	1	
		30

Eleven of these thirty patients received Lugol's solution at some time during their course of treatment.

iodin, given over a period of several months, fail to reduce the size of a diffusely enlarged, nontoxic goiter which is producing pressure symptoms, then a subtotal thyroidectomy should be done. However, in our experience over two years, only one such goiter was removed, and that because the case was erroneously diagnosed. Unless the isthmus is especially enlarged or the gland has reached a size of over 40 grams, there are usually no pressure symptoms which necessitate thyroidectomy. During pregnancy all women in this section of California should receive small amounts of iodin or thyroid substance, or both, unless there is a specific contra-indication. Since Marine and Lenhart's [5] experiments showed that the puppies of iodin-deficient dogs may be goitrous at birth, we have considered it important to give iodin to women with nontoxic diffuse goiters during pregnancy. Thus we protect both the mother and the fetus by this simple procedure.

LIMITATION OF THE NONTOXIC GROUP

The group of patients suffering from nontoxic nodular goiters is a selected one, in the sense that no patients are included who had carcinomas of the thyroid. In general such patients have had goiters for many years, and usually present themselves with one or more symptoms resulting from pressure on structures in the neck or in the upper mediastinum. A few patients have goiters as large as that shown in a slide to be thrown upon the screen.

In these patients the thyroid should be removed to relieve the pressure symptoms and for cosmetic purposes, leaving as much normal tissue as possible. Most of these patients have much greater comfort postoperatively than one might expect, presumably because their symptoms, which have increased gradually over months or years, are suddenly and dramatically relieved following thyroidectomy. Occasionally one must expect such complications as recurrent laryngeal palsies and cachexia strumipriva. In some of these cases nearly all of the thyroid must be removed, and it is sometimes impossible to avoid injury to the recurrent laryngeal nerve. In the seventy-eight cases listed in Table 2, five patients had recurrent laryngeal palsies, one postoperative myxedema, and six postoperative hypothyroidism. It should be mentioned that some of these patients have hypothyroidism when they first present themselves for treatment. The disability from nerve palsies decreases with time, and the hypothyroidism can be satisfactorily treated by administering thyroid substance. If a nodule in the thyroid is increasing in size, a thyroidectomy should be done as soon as possible, since one cannot tell from physical signs or roentgenograms whether cyst formation, hemorrhage or a malignant tumor is responsible. Most clinicians interested in diseases of the thyroid are of the opinion that iodin has little effect on nontoxic nodular goiters, and indeed feel that it is distinctly dangerous to give these patients iodin since hyperthyroidism may be induced. Only a few cases of this latter type have been reported, and I feel that the appearance of the hyperthyroidism is only coincidental with iodin administration rather than the result of it.

TOXIC DIFFUSE GOITER

The etiology of toxic diffuse goiter (Graves's disease) is not known and the treatment, therefore, is empirical. One might say that in no other disease has empirical treatment been so successful. All forms of therapy have, as their final aim, the reduction in the amount of overactivity of the thyroid gland, so that the patient's metabolism falls to normal or low normal levels. This may be done with iodin, subtotal thyroidectomy or x-ray treatment. Iodin does not stop the course of the disease, and should be used mainly as one of the preoperative procedures that will put the patient into the best possible physical condition. Subtotal thyroidectomy, following ten to thirty or more days of preparation with iodin, bed rest, sedatives and a high-caloric, high-carbohydrate diet, is still the treatment of choice for the majority of patients suffering from this disease. X-ray therapy has just as good results in selected patients, but requires a longer time so that the "breadwinner" of a family is seldom chosen. However, those patients with Graves's disease of moderate severity who have no visceral complications, such as mitral stenosis, who can rest part of each day, and who do not live far from the hospital in which they are being treated, can be selected justly for x-ray therapy. Iodin may or may not be prescribed according to the need of the individual patient. General measures which

help the patient to lead a normal life should not be neglected. The equivocal results from x-ray in the past are due to the fact that insufficient x-ray therapy was given and that, therefore, no more could be expected, for instance, than from a hemithyroidectomy. Time precludes any discussion of other forms of therapy for toxic diffuse goiter.

TOXIC NODULAR GOITER

The etiology of toxic nodular goiter, like that of Graves's disease, remains undetermined. For practical purposes subtotal thyroidectomy, after the preparation outlined in the discussion of toxic diffuse goiter, is the best treatment. One cannot tell whether the surrounding glandular tissues or the nodules cause the hyperthyroidism, so that enucleation of the nodules alone is not a rational procedure. We have seen five patients in whom enucleation of the nodules was followed by recurrence of the symptoms of hyperthyroidism associated with the eye signs of Graves's disease, which had not been present during earlier episodes. We believe iodin should be used because one cannot tell whether the nodules or the surrounding gland are responsible. We feel that postoperative complications, such as crises, may thus be avoided. In general, patients with toxic nodular goiter are older and, therefore, more of them have cardiac conditions which also require treatment. The general measures used in the treatment of Graves's disease should be employed also.

The treatment of the overactivity of the thyroid is only part of the regimen that should be outlined for the patient with hyperthyroidism. Stimulants should be avoided, excesses of all kinds should be discouraged, and anxieties should be investigated and either eliminated or treated whenever possible. These measures lessen the number of recurrences.

Iodin is the best medicine for the heart in hyperthyroidism. Digitalis may be used for congestive failure or when it is feared that congestive failure will develop. Auricular fibrillation usually is converted to a normal rhythm after the hyperthyroidism is treated. Quinidin may be given postoperatively in stubborn cases.

The length of time that administration of iodin should be continued postoperatively depends on the type of subtotal thyroidectomy. If a radical subtotal thyroidectomy is done, iodin should be withdrawn in ten days to two weeks following operation. If about 85 per cent of the gland is removed, iodin should be given for six to twelve weeks.

Recurrences are less likely to occur following radical subtotal thyroidectomy. Some surgeons prefer to do a radical operation initially, and then give the patient thyroid substance if he develops hypothyroidism. Other surgeons feel that it is easier to treat recurrence with x-ray or with a second operation. Either method seems reasonable, provided the internist knows which type of thyroidectomy is done and can be prepared to stop iodin or give thyroid, as the case may be. It should be remembered that all well-treated patients have a relative hypothyroidism for six to twelve weeks following operation, and that it is advisable to watch the patient rather than to prescribe thyroid immediately.

THYROIDITIS

In our patients the thyroiditis was the type described by Riedel [6] or that described by Hashimoto,[7] rather than acute thyroiditis with suppuration. The treatment for this type of thyroiditis is usually partial thyroidectomy since it is almost impossible to make the diagnosis clinically. More of the gland should be left *in situ* than in Graves's disease, because there is a tendency to hypothyroidism. Some surgeons merely split the isthmus of the gland to prevent constriction of the trachea and allow nature to do the rest.

CARCINOMA OF THE THYROID

Carcinoma of the thyroid is best treated with the combination of x-ray therapy and surgery. Some patients survive ten years or longer, but any treatment is only palliative. Since it is thought that papillary adenomas frequently become malignant, and since so many aberrant thyroids have the histological picture of papillary adenoma, all aberrant thyroid tissue that is recognized should be removed.

SUMMARY

The treatment of simple goiter should begin during fetal life by administration of small doses of iodin to pregnant women who live in endemic goiter regions.

All methods of treatment of goiter with hyperthyroidism aim at decreasing the overactivity of the thyroid gland. Iodin does not cure hyperthyroidism. Even though iodin is administered continually, the disease is not arrested, but the severity of the hyperthyroidism is lessened. Subtotal thyroidectomy is the treatment of choice in most cases of toxic diffuse and toxic nodular goiter. X-ray therapy in adequate dosage is equally successful in selected cases of toxic diffuse goiter.

Nontoxic nodular goiters should be removed surgically to relieve pressure symptoms, to avert the danger of malignant tumors, and for cosmetic reasons.

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DISCUSSION

H. Glenn Bell, M. D. (University of California Hospital, San Francisco).—Doctor Soley's paper illustrates how much may be learned from a careful study of all patients treated either by surgery or x-ray therapy. I feel that it is always wise to have an internist check the surgical results, not only immediately after surgery, but after several years. The close coöperation of Doctor Soley and the Thyroid Committee with the surgical staff has been of great value in the care of patients with disease of the thyroid gland.

I am firmly convinced that, in treating hyperplasias, a radical subtotal thyroidectomy should be done, leaving perhaps from seven to eight grams of thyroid tissue. Unless one actually has measured and weighed thyroid tissue, however, it will be impossible to estimate the amount of thyroid tissue remaining. It is easier to treat, or to have the internist treat, a mild hypothyroid condition than it is to treat a recurrence or a continuation of the disease. In doing a radical subtotal thyroidectomy the greatest care must, of course, be exercised to prevent injury to the recurrent nerves or the parathyroid bodies.

I agree with Doctor Soley's remarks regarding malignancy of the thyroid gland, especially those relative to aberrant thyroid tissue.

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Leon Goldman, M. D. (University of California Medical School, San Francisco).—Doctor Soley has given an excellent, concise summary of the management of patients with goiter. This subject is such a wide one that it would be impossible for anyone to discuss all the problems covered in the paper.

I should like to say a word about the poor risk goiter patient for, by the recognition of certain factors, we may be able to keep the operative mortality down to a minimum. There are two general reasons for this mortality: one, the prolonged medical treatment with iodin and x-ray, and the other, our tendency to underestimate the patient's condition. The former is obviated by close coöperation between the surgeon and the internist. It is important that the surgeon should see the patient before iodin therapy is started in order to estimate his condition and the operative risk accurately, rather than after the symptoms have been masked by this treatment. Most patients who develop a thyroid crisis after operation have taken Lugol's solution over periods of months or even years. They have become refractory to further iodin therapy, so that we lose the effect of this drug in preparing these patients for surgery.

As a rule, if a patient dies within two or three days following thyroidectomy, we may assume that we have erred in the selection of the time for operation and have underestimated the patient's status. The factors which guide us in selecting the date for surgery are: age, sex, the condition of the cardiovascular system, nutrition, nervous system stimulation, gastro-intestinal manifestations and the basal metabolic rate. A consideration of these factors may enable us to recognize certain danger signals. Patients over forty years of age are poorer risks than those who are younger. The toxic male patient is a more serious problem than the female patient. Those patients who border on myocardial decompensation should receive digitalis before surgery to prevent myocardial failure during the postoperative period. Loss of weight under treatment is an important prognostic sign. Those patients whose nervousness and cerebral excitation are not controlled suggest that they are poor operative risks. Vomiting, diarrhea or rising metabolic rate, or a metabolic rate above forty should cause one to proceed with caution. In addition, it is important to evaluate renal and hepatic functions in the poor risk cases.

It is our experience that doing subtotal thyroidectomy in this type of case presages a smoother postoperative course than stage-operations, if the patient is properly prepared and the time of operation is wisely selected.

HYPOGLYCEMIA: IN RELATION TO THE ANXIETY STATES AND THE DEGENERATIVE DISEASES*

By John F. Quinlan, M.D.
San Francisco

Discussion *by Alfred C. Reed, M. D., San Francisco; I. W. Thorne, M. D., San Francisco.*

THE problem of medicine, in the face of a cumulatively aging population, is the degenerative diseases. Only in their prevention, or the treatment of them in their incipiency, is much to be expected. Consequently, if the modern trend toward prophylactic medicine and the vogue of periodic examinations is to have much value, greater stress must be laid upon anatomically incorrelatable complaints.

Cancer, hypertrophic arthritis, and noninfectious cardio-vasculo-renal disease are the conditions for which we seek the causes and means of prevention. The various estrogens are the only physiologic carcinogenic substances known. The presence of degenerative arthritis is contingent upon the nutrition of the joint structures which, in turn, is dependent upon vascular permeability. Vascular impermeability is a result of sclerosis; sclerosis follows the deposition of cholesterol;[1] cholesterol is the mother-substance of the estrogens,[2] to which it bears a reciprocal relation. Personal observation in a few cases has shown it to be increased in ovarian follicular deficiencies. It has been found to be increased in involutional melancholia, and the arthritis and hypertension of the menopause, in which conditions the hormone has been found to be, respectively, curative and palliative. Cholesterol is a tissue proliferant,[3] and its reduction has been observed as an effect simultaneous with the reduction of leukocytes and the size of organs following x-ray therapy.[4] Overfeeding with dextrose, in mice, has reduced the malignancy of tar tumors (tar is comparable to cholesterol in its chemical structure†), and their tendencies to metastasize.[5]

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* To Dr. Alfred C. Reed, my thanks for his numerous suggestions.

† The carcinogens, *inclusively*, are characterized by a distinctive unity. They are aliphatic and aromatic hydrocarbons, *i. e.*, they are derived from fat and characterized chemically by the benzene ring. They are component substances of living animal or vegetable tissue or decadent (fossil) vegetation—coal and oil—cholesterol of animal tissue, ergosterol (theelin has been synthesized from it) and the other phytosterols of plants, phenanthrene and its various modifications from coal and oil. The "cracking" by which the various carcinogens (tar, paraffin, dyestuffs, antipyrine, benzene, etc.) are obtained from the parent substances is essentially the same as that by which cholesterol is decomposed (combusted) in the body to produce the various sex hormones and, more likely than not, other yet undiscovered tissue proliferants. These processes, the destructive distillation of coal, the fractional distillation of oil, and the catabolism of cholesterol, are effected by the application of heat. Cholesterol, therefore, in the human body, is the focal point in our search for release from the dread diseases of the aged. With this in mind, noting also the endocrine control of metabolism, the occasional cures or dissolutions of cancerous growths in high oxygen tensions, by Coley's fluid or the various endocrine extracts, becomes explicable. Further, it must be realized that, since there are no ovarian follicles in the male or seminephrous tubules in the female, even though female hormones are found in the one and male hormones in the other, the gonads cannot be considered to play an essential part in their synthesis.

Nor need we labor long over the fact that products of protein decomposition (catabolism) are also carcinogenic. Essentially protein is carbohydrate and fat; and it is from the "fat" fraction that they are derived—from a few amino-acids possessing the benzene ring, trypophane, tyrosin, phenylalanin.

TABLE 1.—*Periodic Glucose "Tolerance" Determination*

Cases	Glucose Tolerance	Fasting	One-half Hour	One Hour	Two Hours	Three Hours	Interval Weeks
1	Before treatment	40.0					
	After treatment	115.0	140.0	145.0	(One hour two-dose test)		18
2	Before treatment	71.0	75.0	73.0	72.0	67.0	
	After treatment	91.0	91.0	133.0	111.0	95.0	113
3	Before treatment	110.0	100.0	105.0	109.0		
	During treatment	120.0	60.0	35.0	(One hour two-dose test)		6
4	Before treatment	95.0	90.0	130.0	90.0		
	Without treatment	53.0	75.0	90.2	83.5	60.0	130

It has been shown also that, even under the intense stimulation of dinitrophenol, the body does not lose weight-fats, lipoids in general, of which cholesterol is one, are not catabolized, unless a supply of glucose is available.[6] Cholesterol is not synthesized in the body or only minimally, if at all.[7] That which is in excess of what is necessary for normal tissue structure is either excreted unchanged or, as bile acids, or catabolized with and by the carbohydrates under adequate hormonal (thyroxin) stimulation to CO_2 and H_2O. The estrogens, and the androgens also, are only gradation products in the course of its destruction. The significance of the glycemic level and the factors influencing it, therefore, assumes vastly increased importance.

MANIFESTATIONS OF HYPOGLYCEMIA

The manifestations of hypoglycemia are those of hyperinsulinism.[8] Depending on the patient's glycogen balance, an overdose of insulin may produce headache, "emptiness" in the stomach or gnawing hunger pains, listlessness, faintness, mental torpor or drowsiness, languor or extreme weakness, visual disturbances, profuse sweating, and unconsciousness. Hypoglycemia, therefore, should be accompanied by symptoms which are the manifestations of earlier or lesser reactions to insulin overdosage: headache, hunger pains, listlessness, drowsiness, fatiguability, fragmented vision, vertigo, and sweating. For a clearer comprehension of the various symptoms and their sequence, I have gone to my work fasting from 6 p. m. the previous day, on numerous occasions, with the following results: headache beginning about 10 a. m., becoming worse as the day wore on, often uncontrollable by the noon meal, strong coffee, or 30 to 40 grains of aspirin in the course of an afternoon, and seeming to disappear only after the evening meal, an incapacity for reading, listlessness toward routine activities, and drowsiness. On one occasion, one hour after breakfast, my glycemic level was 105 milligrams.

Formerly we had been taught that the normal fasting glycemic level ranged between 80 and 120 milligrams per cent.[9] Now the minimal level has been set at 100 milligrams per cent,[8] and this seems to be borne out by the many complaints that accompany a glycemic level at the lower figure. In the following group of cases, when usual procedures failed to account for such a wide variety of symptoms as dizziness and fatigue, diurnal somnolence, weakness and anorexia, nervousness ("shivers") and shortwindedness, glucose tolerance tests were resorted to with gratifying results.

It will be noticed that there is no tolerance test for Case 1 preceding the dietary regimen. The patient's condition had become so extreme that she could not stomach the glucose. When given it, she vomited and almost collapsed from the effort.

Curves of Cases 2 and 3 are abnormal in that they are flat—they show no response to the ingestion of glucose. In Case 3, even though the fasting level is normal, as it is practically so in Case 4, the absence of the normal increase in the glycemic level, following ingestion, must be interpreted as hypoglycemic. Case 4 is hypoglycemic in that the response is long delayed and ill-sustained. The second "before treatment" test was made following a lapse of more than two years, during which time her symptoms had been continuous but variable in their severity.

REPORT OF CASES

CASE 1.—A fair-complexioned woman of twenty-five years, sthenic proportions and medium height, underweight, anxious but coöperative, who had been under my care periodically for four years, chiefly for undernutrition. When first seen for the condition relative to our study, her complaints were: nervousness ("shivers"), weakness, and shortwindedness. Her temperature was 98.6, pulse 120, respiration 12, blood pressure 120/70, weight 107 pounds. She was placed on Lugol's solution, phenobarbital, and frequent small feedings of glucose. In the course of a week her condition had become worse, with additional symptoms of marked listlessness, dizziness, heaviness of the eyes, and continual yawning. She menstruated four to five days in a twenty-eight-day cycle. The flow was moderate in amount and was neither preceded nor accompanied by discomfort. Excessive hairiness was the only abnormality noted on physical examination; pulse 100, blood pressure 110/60, weight 107 pounds. Lugol's and phenobarbital were discontinued. Two days later there was postcibal vomiting, followed by epigastric soreness. At this time her glycemia was 40 milligrams per cent; blood count normal, except for moderate neutrophilic leukocytosis; basal metabolism minus thirteen. There was slight improvement during the following week on frequent feedings of cream only, in addition to her regular meals; pulse 95, blood pressure 130/60, weight 108 pounds. The following two weeks on thyroid there was moderate improvement in symptoms, though languor continued. Her menses was scantier than usual; pulse 90, blood pressure 120/60, weight 112 pounds. The next month thyroid was replaced by theelin, with marked results. Menses was still subnormal; pulse 80, blood pressure 130/60, weight 115 pounds. Cream, as additional feeding, was discontinued, and theelin replaced by amniotin. Improvement continued during the next two months; pulse 75, blood pressure 120/60, weight 119 pounds; glucose tolerance, fasting 115 milligrams, one-half hour 140 milligrams, one hour 145 milligrams (one hour two-dose test).

On one occasion, when not accompanied by her mother, to a question previously put but not answered, she replied

that for several months before coming she had been worrying over an unmarried sister who had become pregnant, fearing that their mother would be informed of it. At the time, several months after an abortion had been procured, she was still worried for the same reason.

Comment.—This patient has all the criteria for a diagnosis of anorexia nervosa, with an aversion for food, hairiness, progressive oligomenorrhea, undernutrition, and a low basal metabolism,[10] together with hypoglycemia, which, to my knowledge, has not been observed as a feature of this condition, and the anxiety state upon which the train of symptoms is based. The gradual subsidence of the patient's fears, with the passage of time, may have been as/or more effective in curing her condition as any remedy prescribed.

* * *

CASE 2.—A stocky, obese, congenial male of medium height, age thirty-five, whose complaints were: dizziness and faintness ("all-gone feeling") which had been present for three years, but which had become very aggravated during the past three months. He had an excessive thirst and polyuria, and felt under a nervous tension all the time. His illness fluctuated with his social conditions, being aggravated according to the degree of insecurity. Three months back, he lost his job: earlier, he had taken "cuts," had lost a child, as well as borne with his father's unemployment.

He was five feet six inches, weighed 178 pounds; tonsils injected, many dental fillings, liver three fingers-breadth below the costal margin, skin brawny and scaly, hands chubby; pulse 95, blood pressure 130/100; Wassermann negative; urine and blood count normal; basal metabolism minus 17; glucose tolerance, fasting 71, one-half hour 75 (glycosuria), one hour 73, two hours 72, three hours 67.

The following two weeks on thyroid and digitalis effected slight improvement; pulse 95, blood pressure 110/70, weight 176 pounds. A week later he was worse: "dazed"—most pronounced when hungry and most often in the morning. He perspired more freely. Thyroid was decreased, and he was advised to eat lightly but more frequently, particularly of the coarser carbohydrates. He was given a digestive mixture. The following month there was marked improvement, which was most noticeable after pleasure trips. The skin was less brawny, pulse 85, weight 179 pounds. Symptoms were aggravated on withdrawing the digestive mixture (takadiastase, atropin, ox bile). In the following month his father died, all symptoms returning in a more aggravated form, together with nausea and vomiting, and ureteral and biliary colics and hematuria. Gallbladder and pyelographic studies were normal. During the next four months, without change of regimen, there was continuous improvement, except for palpitation; pulse 115, weight 177 pounds. Six weeks later there were no complaints; pulse 90, weight 181 pounds.

He returned again eighteen months later, complaining of palpitation, lethargy, and constipation; pulse 95, blood pressure 140/100, basal metabolism plus 15, glucose tolerance, fasting 91, one-half hour 91, one hour 133, two hours 111, three hours 95.

Comment.—Though, in the patient's physique—stockiness, obesity, spade hands, brawny skin, and palpable liver—there is evidence of dysfunction independent of the phase of his illness which concerns us here, it is quite obvious that an anxiety state conditioned much of his illness. And it is evident that release from it was coincidental with a sense of well-being. It is significant that two years after the occurrence of his reverses, during which time had its calming effect, his basal metabolism and glucose tolerance, to a degree, had returned to normal even though the symptoms were similar to the original ones. As the patient did not return for further treatment, the presumption is permissible that they were transitory.

CASE 3.—A tall, slender, undernourished, fair-complexioned, brusquely affable woman, whose complaints were weakness and anorexia. Two years earlier the patient had similar complaints, with anemia. Her diet was deficient. Her menses followed a five-day course in a cycle of twenty-eight days. They were scanty and accompanied by slight pain. Aside from a general pallor, the physical examination was normal; height five feet seven inches, weight 132 pounds, pulse 90, blood pressure 110/70. Laboratory: Gastric analysis 10 degrees HCl at ninety minutes; blood count—color index 0.8, hemoglobin 61 (Sahli), erythrocytes 3,500,000, with slight acromia, anisocytosis, and poikylocytosis; leukocytes normal.

For two months she was given lextron, six capsules daily, and a weekly injection of 3.0 cubic centimeters of liver extract with negligible results; color index 0.9, hemoglobin 75, erythrocytes 3,500,000, with no change in the character of the cells; weight 139 pounds.

Recollecting that the patient when first seen, was in a hysterical collapse, occasioned by her husband's late and rather ebullient return from the "fights," that his income was contracted, and that it was a matter of much worry for her, the possibility of a chronic hypoglycemic state was considered: fasting 110, one-half hour 100, one hour 100, two hours 109; there was active diuresis.

Lextron was replaced by iron-ammonium-citrate, and she was advised to eat frequent small feedings, particularly of carbohydrate. Two months later the glucose tolerance was: fasting 120, one-half hour 60, one hour 35. There was diuresis. Blood count: Color index 0.9, hemoglobin 80, erythrocytes 4,000,000, with little change in the character of the cells.

A week later she complained of heartburn and weakness on rising, stating that they were present for three weeks, and that she had been troubled with them for the past three years. During the following two months, on a digestive mixture, there was a decided improvement. Then tiredness recurred at her menses.

Comment.—The emotional state, deranging the normal gastro-intestinal functions of motility, secretion, digestion, and absorption,[11] was partially offset by supplying the deficiency in the form of a digestive mixture: atropin, which produces muscular relaxation and inhibition of secretion of the stomach and pancreas;[12] takadiastase, a digestant of starch; and ox bile, chalagogue and choleretic stimulant of hepatic secretions, as well as emulsifier of fats. Glucose was absorbed as diuresis followed its ingestion. It is probable that the immediate absorption of glucose, inducing a simultaneous discharge of insulin,[13] effected its rapid conversion to glycogen in a body depleted of its reserve.

* * *

CASE 4.—A tall, slender, fairly well-nourished, pleasant girl of twenty years, whose chief complaint was uncontrollable diurnal somnolence.

Her illness began a year earlier, progressing slowly, accompanied only by an occasional headache. There were no other mental symptoms until shortly before her first visit, when drowsiness affected her. It would come without premonition at any time. Occasionally, under emotional strain, she was overcome by a general weakness in which she was unable to sustain her own weight. She said she was "likely to slump away and, upon recovery shortly after, find herself sitting down." Menses followed a four- to five-day course in a cycle of thirty days; the flow was moderate, without distress.

Following graduation from school, she found it difficult to gain employment; and as she was an orphan, under the best of circumstances felt the sting of a social handicap.

Physical examination was normal, but for slight undernutrition; pulse 95, blood pressure 120/70, weight 130 pounds, height five feet nine inches; laboratory tests, including blood count, urinalysis, and Wassermann, were normal; basal metabolism, minus 7.

During the next thirteen months, though her somnolence had been continuous, no relief was sought. An impacted molar was removed. A year later her glucose tolerance

was: fasting 95, one-half hour 90, one hour 130, two hours 90; erythrocytes 4,100,000, hemoglobin 77, leukocytes, 7,700, with a normal differential.

The response to frequent small feedings of dextrose, together with increased intake at regular meal times, was excellent. It continued for two months, when a recession set in. She had become disgruntled over her circumstances, which she was finding impossible to improve.

There was a lapse of sixteen months, when she again appeared with much the same complaints, even though her environmental adjustment had become satisfactory. She had not followed instructions during the time. A glucose tolerance then showed: fasting 53, one-half hour 75, one hour 90.2, two hours 83.5, three hours 60; basal metabolism, plus 26.

Comment.—If the psychic element at play is not anxiety, at least, there is the consciousness of frustrated effort or ambition which was not a passing whim, but a long-continued attitude.

MOST FREQUENT CAUSE OF HYPOGLYCEMIA

An oversupply of insulin, the hormone which controls the conversion of glucose into glycogen,[18] is obviously the most direct though not necessarily the most frequent cause of hypoglycemia. In the absence of anatomic pathology in the islets of Langerhans or in the glands having a symbiotic relation, such a conclusion can be only provisional. The complex interplay of the endocrine glands renders it extremely unwise to attribute to any one of them a particular effect except where tests, such as there are for the follicular hormone, demonstrate its preponderant influence. The glucose tolerance test, though a test of insulin activity, is not specific as a test for an excess or lack of that hormone. Nor is the determination of the fasting blood level an adequate index of normality. The status of the body's cells with relation to rest and activity [9,18] determines whether or not they will be resistant to its influence, insulin being more effective when the pH of the tissues and, consequently, the blood is high, *i. e.*, inclines to alkalosis, as in repose, depressed states, and hyperventilation, an equivalent of alkalosis in physiological terminology. Conversely, the cells are more resistant in states of relative acidosis, conditions characterized by a lower pH, such as muscular activity, or long-continued fasting or fevers. Likewise, as cellular activity is dependent upon thermal conditions, heat, by depressing the body's functions, will account for hypoglycemia. It may rest upon such a simple matter as a deficiency of glycogen, a consequence of faulty dietary habits. But more directly than any other factor a hypoglycemic state is conditioned by the mental attitude or emotional status, as by apathy or anxiety.

SECONDARY CAUSES

Secondary, or dependent causes, resultants of the effect of the mental or emotional disequilibrium on physiological processes, may be: direct, through the autonomic innervation of the gastro-intestinal tract,[10,14] affecting adversely its various functions of secretion, motility, and absorption; indirect, through dyspituitarism.[14] This may express itself either through the secretions of its posterior lobe affecting adversely the motility of the intestine, or through the altered trophic action of the secretions of the anterior lobe disturbing the synergism of the endocrine system. The dystrophic effect through the thyroid, by lowering its secretion, would be to lessen cellular activity and, therefore, the need of glucose and the quantity of glycogen necessary to be mobilized. The adrenal cortex controls the retention of sodium chlorid.[15] By its osmotic attraction the supply of water, the medium necessary for the "oxidative" processes, is regulated. A dyssynergic deficiency effects simultaneously a lower concentration of sodium chlorid and water, and consequentially, that of the other electrolytes, among them glucose. The adrenal medulla controls the hydration of glycogen (glycogenolysis). Its deficiency effects a fixation of glycogen which results in a lowered concentration of glucose. Follicular hormone enhances the action of insulin, the dehydration of glucose, or stimulates the islet cells to increased production. Its hypersecretion, by complementing the action of insulin in immobilizing glucose or, conversely, by interfering with the mobilization of glycogen, lowers cellular metabolism. The supply of available glucose for the adequate reduction of the other combustible substances, proteins and lipoids, being thereby adversely affected, cholesterol and the various gradation products in the course of its destruction, accumulate in excess. On the vascular tree they produce, by irritation, spasm (hypertension) and/or hyperplasia-arteriosclerosis.[16] Cholesterol and the sex hormones, at least, which are derived from it, are active tissue proliferants. Neoplasm is simply an aphysiologic proliferation. The deposition of cholesterol, the body fluids being limited in their capacity of solution inversely with their pH—again a matter of systemic tissue activity—also results in irritation (spasm or claudication) and neoplastic proliferation.

CONCLUSIONS

Hypoglycemia may be a transient phenomenon, but there is good reason to hold that it is a constant feature of chronic states that are significant from the standpoint of prophylaxis in cancer, degenerative arthritis, and noninfectious cardio-vasculorenal disease.

Hypoglycemia is pathognomonic of an anxiety state; treatment directed against it primarily is only symptomatic and highly empiric.

Anorexia nervosa, as a disease, is not confined to women, the symptom-complex being modified only by the differing gonadal component. It is a redundancy in diagnosis, and serves only to confuse a phase of medicine not yet clearly defined, psychophysical interrelations. It distorts, by exaggeration, one symptom, anorexia, in a train more adequately defined under the generic title, "anxiety neurosis."

An anxiety state is a primary etiologic factor in the degenerative diseases. Endocrine incoördination is its immediate effect. Defective cholesterol catabolism is the result.

The prevention of the degenerative diseases lies in the body's capacity completely to excrete or catabolize cholesterol which is in excess of the body's needs.

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DISCUSSION

ALFRED C. REED, M.D. (350 Post Street, San Francisco). I have read Doctor Quinlan's paper with extreme interest. It is an excellent example of much-needed integrative thinking in medicine. It brings together disparate and apparently inconsistent data on the degenerative diseases, and suggests an underlying uniformity which is logical and fully worthy of intensive study. His first paragraph epitomizes the recognized importance of such study. It is greatly to be hoped that Doctor Quinlan will be able to continue and extend these ideas.

I. W. THORNE, M.D. (490 Post Street, San Francisco). To discuss Doctor Quinlan's paper intelligently one must needs be a biochemist, endocrinologist and physicist at one and the same time, which I am not. Nevertheless, some of his observations regarding the anxiety state and its accompanying or following bodily dysfunctions are very interesting, and I believe, with Doctor Quinlan, undoubtedly the starting point of permanent destructive process as evidenced in carcinoma, arteriosclerosis and its concomitants as well as multiple arthritis.

So many discoveries regarding the interrelations of the several endocrine glands and their various and sundry hormones are presented that a very clear and logical survey of these interrelations and the effects of the disturbance of these interrelations must accompany any discussion of a state purported to result from such disturbance or imbalance.

I know from experience that the exhibition of insulin in small doses with the forced feeding of carbohydrates (sugar) in the condition of depression, physical and mental, which accompanies the later stages of carcinoma, will often make such a change for the better that one is almost compelled to believe that a miracle has been performed and that his patient has been cured. However, this great improvement is but transitory, for within a fortnight or so the cancer process regains the upper hand and the patient slips back into weakness, emaciation, and anemia, all of which were so much abolished.

I have wondered about such an ephemeral improvement, its cause, its decline and its disappearance; may not the lack of some other endocrine product, some hormone, be at the bottom of such disaster or may not the lack, originally, of some hormone be the cause of the original disease?

That anxiety states are the cause of duodenal and pyloric spasm I have not the slightest doubt and, if long-continued, cause duodenal ulcer.

‡ If, as Burns says,[17] speaking of the synthesis of glucose in plants, "Carbon dioxid and water are fully oxidized," and chemical principles apply indiscriminately in biological processes, then the process by which plant or animal (glycogen) starch is converted into their respective number of absorbable glucose molecules and the assimilation of these glucose fractions into glycogen molecules specific for human flesh, or the reconversion of human glycogen to glucose cannot be said to have been accomplished likewise by oxidation. The assimilation of glucose into glycogen by the body is by condensation or dehydration, and the reversion of glycogen to glucose is effected by hydration or hydrolysis. Glucose, then, in being catabolized, is subjected to reduction. Insistence upon this distinction is important, as it helps to eliminate much of the confusion in the interpretation of endocrine implications in metabolic processes.

POLLEN SURVEY*

A REPORT ON THE ARCATA DISTRICT HUMBOLDT COUNTY, CALIFORNIA†

By WILLIAM C. DEAMER, M.D.
HARRY L. JENKINS, M.D.
Arcata
AND
DOROTHY SCOTT LAZARUS
San Francisco

DISCUSSION *by R. W. Lamson, M.D., Los Angeles; H. E. McMinn, Professor of Botany, Oakland.*

RECENT monographs on the subject of pollenosis have been inadequate in regard to the pollen situation on the Pacific Coast. One of the authors (H. L. J.), in 1935, called attention to the desirability of an atmospheric pollen count in Humboldt County in the northern California region. Technique and organization for such a study had been developed in the Pediatric Department of the University of California for a previous survey.[1] It was decided, therefore, to coöperate in the present study, which approaches the problem from an angle different from that used by Rowe and Howe in their botanical survey of northwestern California.[2] They employed the method of field survey.

TOWN OF ARCATA

Arcata is a town of 2,000 population, situated 290 miles north of San Francisco, on Humboldt Bay, and is in the coastal redwood (Sequoia sem-

* From the Department of Pediatrics, University of California Medical School, San Francisco.

We wish to thank Professor H. E. McMinn of Mills College, Oakland, who acted as consultant in this survey.

† An atmospheric pollen count of Arcata in Northern California.

TABLE 1.—*Record of Atmospheric Pollen for Arcata, California, 1935, 1936*

Common Name	Botanical Name	1935 August 24-31	1935 September 1-7	8-15	16-22	23-30	1935 October[1] 1-7	8-15	1935 November 1-7	8-15	16-22	23-30	1935 December[2] 1-7	8-15	16-23	1936 January[3] 24-31	1936 February 1-7	8-14	15-21	22-28	1936 March 1-7	8-15	16-23	24-31	1936 April 1-7	8-15	16-22	23-30
Grasses																												
Grass family	Gramineae	8	3	12	9	8	1	3	0	0	0	0	0	0	0	0	1	2	0	3	1	1	0	3	3	7	11	25
Weeds																												
Ragweed, etc.	Ambrosieae	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	5	1	1	0	2	3	0	0	0
Sagebrush	Artemisia	1	5	3	5	3	1	0	0	0	0	0	0	0	0	0	0	0	0	11	1	1	1	0	0	3	1	2
Amaranths Chenopods, etc.	Amaranthaceae / Chenopodiaceae	3	0	6	5	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Plantain	Plantago	1	7	1	2	5	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dock	Rumex	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	6	8	22
Nettle	Urtica	0	0	0	0	11	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trees and Shrubs																												
Alder	Alnus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	3	12	124	9	2	5	1	3	6	2	0	2
Cypress family	Cupressaceae	0	0	7	48	21	5	3	4	1	8	3	12	5	44	210	25	28	18	7	5	13	4	14	18	9	4	2
Silk-tassel tree	Garrya	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	3	0	0	0	0	0	0	0	0	0
Pine family	Pinacae	1	1	1	1	1	0	0	0	1	0	0	2	0	0	1	8	7	1	5	3	30	59	12	5	12	7	11
Cottonwood	Populus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4	7	1	0	0	0	0	0	0	0	0
Oak	Quercus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0	0	0	3	0	0	5	0	0	1	1	0
Willow	Salix	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	3	1	0	0	0	0	0	0	0	0
Elm	Ulmus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12	0	4	2	7	12	0	1	2	4	1	0	0

NOTE:—The numbers indicate the total number of pollen grains which fell on an area of one square foot during the period of one week.
[1] The record is missing for the two weeks of October 16 to 30.
[2] The record is missing for the one week of December 24 to 31.
[3] The record is missing for the three weeks of January 1 to 23.

TABLE 1.—*Record of Atmospheric Pollen for Arcata, California, 1935, 1936 (Continued)*

Common Name	Botanical Name	1936 May[4] 8-15	16-23	24-31	June 1-7	8-15	16-22	23-30	July 1-7	8-15	16-23	24-31	August 1-7	8-15	16-23	24-31	Glycerine: September 1-7	8-15	16-22	23-30	October 1-7	8-15	16-23	24-31	November[5] 8-15	16-22	23-30
Grasses																											
Grass family	Gramineae	41	70	28	44	253	613	161	87	262	168	93	62	80	72	41	32	14	7	12	11	14	32	25	11	3	7
Weeds																											
Ragweed, etc.	Ambrosieae	1	1	3	1	1	20	19	12	25	33	38	32	35	32	11	5	3	16	3	21	13	8	4	7	4	1
Sagebrush	Artemisia	5	5	0	1	3	4	5	1	5	1	11	1	2	1	1	1	3	11	1	1	5	1	2	1	1	0
Amaranths Chenopods, etc.	Amaranthaceae / Chenopodiaceae	0	8	0	1	1	12	14	12	7	4	7	5	4	1	1	0	2	0	1	1	1	3	4	1	1	0
Plantain	Plantago	0	4	8	50	40	74	27	49	22	56	49	44	35	35	5	3	1	4	0	3	6	8	4	2	2	1
Dock	Rumex	8	18	3	19	20	31	12	16	4	1	4	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0
Nettle	Urtica	0	2	2	3	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trees and Shrubs																											
Alder	Alnus	2	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cypress family	Cupressaceae	7	1	1	7	1	5	3	0	3	1	1	1	1	3	5	2	0	1	0	1	0	1	1	1	1	0
Silk-tassel tree	Garrya	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pine family	Pinacae	16	12	4	2	2	1	1	1	1	3	1	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Cottonwood	Populus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oak	Quercus	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Willow	Salix	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Elm	Ulmus	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0

NOTE:—The numbers indicate the total number of pollen grains which fell on an area of one square foot during the period of one week.
[4] The record is missing for the one week of May 1 to 7.
[5] The record is missing for the one week of November 1 to 7.

Fig. 1.—Showing location of Arcata

pervirens) belt. Considerable fog and a generous rainfall, from October through April, are common to this area. At Eureka, eight miles from Arcata, the annual rainfall averages 38 inches (Fig. 1).

The lowest mean monthly temperature is 47 degrees, and occurs in January. The highest mean temperature is 56.2 degrees, and occurs in August. Thus, the seasons are mild and not markedly differentiated. The pollinating periods of grasses and weeds are correspondingly long, a characteristic also of the San Francisco area.

AIR SURVEY TECHNIQUE

The observations recorded in this report extend over a period from August 24, 1935 to November 22, 1936, with the omission of certain slides in transportation and other causes. As in a previous study, a standard size microscope slide, coated with vaselin, was exposed daily for twenty-four hours. A small tin slide holder of the type described by Acquarrone and Gay [3] was used. This was placed on a second-floor window ledge of an apartment building on the north side. At intervals of from two to four weeks the slides thus exposed were sent to the Pediatric Department Laboratory at the University of California Hospital for the identification and counting of pollen grains. The technique of counting was the same as in a previous survey in San Francisco.[1]

POLLINATING SEASONS

The pollinating season for grasses and most weeds was even longer than was found in the San Francisco study in 1933. Although due allowance must be made for differences in the position of slide holders, as well as variations from one season to another, it is also apparent that there is a heavier grass pollen crop at Arcata than in San Francisco. The average of four San Francisco stations showed about 210,000 grass grains per square foot for the entire year, while the Arcata station showed ten times this amount. Pollen from the ragweed tribe was also more abundant at the Arcata station in the years studied. The average total number of ragweed grains per square foot for San Francisco in 1933 was 21,500, whereas the total for Arcata over a year's period (November, 1935 to November, 1936), was 361,000 grains. These figures include false ragweed (Franseria) and cocklebur (Xanthium), as well as true ragweed (Ambrosieae), as accurate differentiation between the pollen grains of these members of the ragweed tribe was not considered possible. As true ragweed (Ambrosieae) tends to be more important in pollenosis, and as Durham [4] has reported such low figures for Ambrosieae at other coastal stations, a more complete botanizing of this district would be of interest in regard to further differentiation within this group of pollens.

Plantain pollen, likewise, was more abundant at Arcata in 1936 than at San Francisco in 1933, while sage pollen was somewhat less so. Among the trees the absence of acacia and eucalyptus, and the small amount of oak pollen at Arcata, are the outstanding differences in the two stations.

In general, the pollenating seasons, indicated in Rowe and Howe's Botanical Survey of Northern California,[2] for Humboldt County, in which Arcata is located, agree well with those of the present report. However, these authors make no mention of plantain pollen, which we found to be abundant at Arcata from June to September.

MEDIA FOR SLIDES

During the course of the study, we became interested in possible advantages of a glycerin and methylene-green mixture over vaselin as a coating for slides. Wodehouse [5] feels that glycerin is superior, as it expands the pollen grain and thus reveals certain features not seen in the collapsed dried state usually found in vaselin slides. He emphasizes the point that germinal pores, which are otherwise hidden by a collapsed "folding membrane," may become visible, and that details are brought out by the addition to the glycerin of methylene-green stain. Accordingly, we compared the two media on slides exposed in San Francisco. Identification was occasionally, but not always, easier on the glycerin slide due to the expansion of the pollen grains. However, all grains were not expanded, collapsed forms being frequently seen on these glycerin slides. It was apparent also that some of the previous "unknowns" on vaselin slides were expanded forms with which we were not familiar at the time. When uncoated slides were exposed, expanded forms were usually collected. It is our impression that where a considerable variety of pollen is in the air, identification can be made easier by exposing a vaselin and a glycerin-coated slide simultaneously side by side. In identifying expanded grains the illustrations of Wodehouse are very helpful. Glycerin slides, freshly prepared with known pollens, are also a great aid.

As noted in Table 1, the last few months of the study were conducted with glycerin-coated slides.

Some loss of detail occurred due to the length of time which elapsed before the slides were examined. Although it was not possible in this instance, glycerin slides should preferably be counted within twenty-four hours after exposure.

FACTORS AFFECTING POLLEN COUNTS

It is possible that glycerin-coated slides tend to collect slightly more pollen than slides coated with vaselin. In studying this point, slides of each type were exposed side by side for seven months. They were changed every day or two. In an area of 1.8 square centimeters, a total of 1,972 grains were collected in the vaselin slides, while 2,318 grains were collected in the glycerin slides.

Pollen itself seems to have some adhesive properties, and position of slides rather than type of coating may make for the greatest difference in amount of pollen caught. For example, when slides were held at their end by a clamp and projected over the edge of the roof with one surface coated and the other not, the uncoated surface would frequently catch more pollen than the coated surface, provided it was the underneath surface. This is because the undersurface is the one facing the upward current of air usually found on the side of buildings.

We also exposed two vaselin and two glycerin slides, side by side, for varying periods. While the method of counting the number of grains seen in four trips across the slide occasionally gave great variations in two identically exposed slides, these variations were fairly well equalized in totaling the grains caught over an eight-day period. We wish to emphasize, however, that in pollen counts of this type the most reliable information is that obtained in respect to type of pollen and length of season, rather than quantitative values. Due to the variations in quantity which position and location of the slides give, only very marked quantitative differences between stations are of significance.

Medical Center.

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DISCUSSION

R. W. Lamson, M. D. (1930 Wilshire Boulevard, Los Angeles).—The importance of pollen in clinical allergy may be investigated from at least three standpoints: (1) A field survey of plants and pollens; (2) skin tests with dependable extracts; and (3) clinical correlation with the data yielded by the previous examinations.

The first subdivision most closely relates to the article under discussion. It forms such a highly specialized field of biology that few expert botanists, and fewer physicians, have more than a superficial knowledge of its problems. Many "botanic surveys," especially those in which common names only are used, and those designating the results of a series of skin tests as a pollen survey, reflect that lack of knowledge. It is of prime importance to determine what plants are grown in the patient's community and, in addition, the atmospheric pollen count. The latter may include pollens brought in from a considerable distance. Until recently, such information was practically nonexistent—and still is for much of the western section. The study reported by Deamer, *et al*, is a necessary step in overcoming such deficiencies. Durham, to whom they have referred, is our most ardent champion of pollen counts, and his contributions have been invaluable. His investigations have centered in areas east of the Rocky Mountains, and are not necessarily an answer to the western problem. For example, in many eastern states the "fall" pollen factor may be quite well studied by a consideration (and the use), of a half dozen pollens. Contrary to popular belief, these need not include goldenrod. The ragweed type is of major, if not sole, importance in most areas. Hence Durham's grouping of several composites into this type is adequate, and almost a necessity in view of the magnitude of his study.

In the western territory a very different situation exists. Many articles have called attention to the great variation in plant distribution within a few miles, and, equally important, the variation in time of pollination from year to year for many species.

The second main heading also has a bearing upon the inadequacy of grouping pollens into such a mixture as "ragweeds," "grasses," and Chenopodiaceae (chenopods). The school which believes in the specificity of pollen reactions would like to know, first, the reactions of a patient to the more important species within a genus; second, whether these occur in the sections where the patient has symptoms, and third, whether they might have been pollinating at that time. Failure to emphasize this clinical correlation forges the weakest link in a scientific chain, otherwise potentially strong.

The authors have correctly emphasized many of the technical difficulties, and at the same time the great importance of "a more complete botanizing" of their district. It is suggested that some of the difficulty in distinguishing between the pollen grains of members of the ragweed tribe may be offset by a thorough ecologic study of the area. Each year one should keep in touch with the general features of growth of the plants, the date and duration of pollination for each major species. If one is quite familiar with each species, or better still, is in touch with a pollen collector, he may readily determine which plants are profuse pollinators and the general physical characteristics (such as light, dry, etc.), of each pollen. Such information is as valuable as pollen counts.

In conclusion, it seems safe to state that many patients in the western third of the United States experience as severe allergic symptoms due to pollens as are experienced by those in the remainder of the country. The findings at Arcata by Doctors Deamer, Jenkins, and Lazarus, and in the other articles they referred to, as well as unpublished studies in Los Angeles by Wodehouse and myself, confirm the general impression that the maximum "pollen count" in the West never approaches the average reported for the central states. The clinical significance of pollen cannot be anticipated by a mathematical comparison of the count in two widely separated sections. This lends further emphasis to the detection of local pollens, such as plantain, to species within the genera and also to botanic comparisons, such as these authors made between Arcata and San Francisco.

*

H. E. McMinn, Professor of Botany (Mills College, Oakland).—The geographical area included in the pollen survey made by Deamer, Jenkins, and Lazarus is interesting botanically. The area around Arcata, California, belongs to the Coastal Transition Life Zone, a belt in which plants of many species can thrive and produce pollen over long periods without danger of killing frosts. This area receives more rain and fog than that around the San Francisco Bay and, therefore, it is not surprising that the authors report a longer pollinating season for grasses and weeds about Arcata. Velvet Grass (Notholcus lanatus), occurs more abundantly in the northern coastal area than around the San Francisco Bay, and that would partly account for the greater number of grass pollens reported by the authors. Plantain thrives well in semidisturbed and grazed-over areas all along the Pacific Coast. I would expect pollen of this plant in the Arcata area, although no

mention was made by Rowe and Howe in their botanical survey of northwestern California.

Local pollen surveys, such as the one just completed by the authors of "An Atmospheric Pollen Count of Arcata in Northern California," should not only be made in a greater number of areas in California, but the results should be studied by members of the medical profession practicing in those areas. These results should also become a part of the routine diagnosis of pollen hay-fever.

RELATION OF CHILDHOOD INFECTIONS TO BEHAVIOR*

By Arthur R. Timme, M.D.
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IN working with a large number of school behavior problems over a period of years, especially in a large metropolitan system in which the mentally defective are soon detected and provided for, one sees the emergence from the daily material of the neurological clinic, a frequent and typical picture which I wish to describe in this paper. With striking frequency, teachers and nurses refer a child because he is "nervous," "he won't concentrate or sit still," "he is into everything," "I can't do a thing with him," "he takes up most of my time," etc. Out of 105 consecutive cases referred, seventy-one were of this type.

CHARACTERISTICS

The following characteristics are more or less common to this type:

1. Behavior, as described in the complaints enumerated above, is hyperkinetic, restless, flighty, uncontrolled, impulsive, explosive, and overaggressive.

2. Certain physical signs and symptoms are found, *e. g.*, a muscular unsteadiness, as shown in the outstretched hands, of varying degree, sometimes going as far as choreiform jerkings; occasional tremors; poor coördination; hyperactive reflexes; occasional increased salivation; occasional enuresis, polyuria and disturbed water balance; temper tantrums resembling automatic rages; fatigability; obesity or malnutrition; disturbances of sugar tolerance; tendency to high fevers; headaches accompanied by digestive disturbances; migranoid attacks; disturbances of sleep.

3. A history of definite change in behavior, growth, development, etc., following an illness, especially when this illness involved high fever or delirium or stupor. Head trauma, especially with unconsciousness, may have been the starting point.

RELATION TO ENCEPHALITIS

This combination of history, behavior and findings immediately suggests encephalitis. Encephalitis has been known to complicate the childhood infections for a long time. In fact, there is scarcely an infectious disease of any kind which encephalitis does not complicate. One need only to peruse the titles under that heading in the Index Medicus to see a list of most known diseases. Measles seems to be the chief offender in this respect, and there are countless case reports and many pathological studies of measles-encephalitis.[1,2] In the last decade or so, postvaccinal encephalitis has also been described, the later sequels of which are studied by Kaiser and Zappers of Munich.[3] Scarlet fever,[4] chicken pox,[5] otitis media,[6] pneumonia,[7] undulant fever,[8] and numerous other infections are described time and again as causing encephalitis.

Pathological studies seem to present a fairly uniform picture, no matter what the disease causing the encephalitis—a uniformity quite paralleled by the clinical aspect. Knauer[11] and Jaensch of Breslau point out the similarity of all encephalitides. Globus[12] of New York says: "By placing side by side the various forms of inflammatory disease of the central nervous system, a striking confluency of all the encephalitic forms has been revealed, and it has been suggested that the minor histologic differences express mainly the degree rather than the character of the pathologic process, and it is not unlikely that there are variations in intensity of the excitant and variations in the local vulnerability of the tissue rather than with distinct types of causative agents."

The specific relation of encephalitis to behavior problems in children, however, has not engaged much attention until recent years. In 1922, Bonhoeffer[9] described residuals of disturbed behavior in children who had had epidemic encephalitis. A number of other similar descriptions appeared shortly afterward, and in 1925 Hall[10] gave a classification and description of the sequels of encephalitis which has coincided with most of the later work and still holds good today. He groups the after-effects as follows: (1) the idiot, or mental defective group; (2) the Parkinsonian group (this is an extremely well-known sequel and not within the scope of this paper); (3) the Apache group (the more pronounced aggressive, antisocial children, dirty about their person, sex-delinquent and showing occasional homicidal tendencies; (4) the "difficult child" group. (4) differs from (3) only in degree and he describes these children as hyperactive, excitable, irritable, quarrelsome, uncontrollable, fatigable, lacking concentration, drowsy in the daytime and sleepless at night (the so-called sleep reversal). They show a loss of emotional affectivity, which deprives the parent of the chief means of guidance and control: "as though astride a colt being broken to harness and the reins suddenly gave way. The whip is now worse than useless and it requires good horsemanship and suitable country to regain control and escape trouble." How apt the simile in every detail! Then came the now classical work of Bond[13,14] and his coworkers in Philadelphia—a detailed study and treatment in a hospital school of a group of postencephalitic behavior disorders over a period of ten years. This experiment served to establish among our concepts the definite syndrome of postencephalitic behavior disturbance. However, the boys and girls that Bond worked with represent the more extreme and severe results of the encephalitic process upon the behavior of children. This concept, nevertheless, is the prototype of the present study, with some slight variations in identity and greater variations

* Read before the Neuropsychiatry Section of the California Medical Association at the sixty-seventh annual session, Pasadena, May 9–12, 1938.

in degree. Most of our children were not "bad" enough to have to be sent to a hospital (although many should have been); yet they created everyday school and home and community problems of sufficient gravity to merit study and treatment.

OTHER TYPES

Many severe modifications of the machinery of behavior, the nervous system in its entirety, go unrecognized in their inception. For instance, a child has scarlet fever and eventually recovers. During the course of the illness there is a high fever with periods of delirium; there may not be any meningitic or focal signs at all. After recovery no gross neurologic signs are present and the doctor says he will be all right. At the age of five or six, the more subtle changes in personality, nervous integration, etc., are not so apparent. The child is still "run down" and receives a considerable amount of care and indulgence, so that less profound changes are not so readily discernible. Later on, when exposed to competition with other children—*e. g.,* in school—the signs and symptoms that go to make up this syndrome unfold themselves. Everyone has measles and many of us fall on our heads at some time or other during childhood. These are just some of life's experiences, and most of us remain unscathed thereby, we hope. Naturally, not every infection or trauma disturbs those parts of the brain that are concerned with self-control, integration, concentration, inhibition of indiscriminate activity, resistance to fatigue, coordinate functioning of the bodily musculature and a number of other functions. Incidentally, these seem to be widely scattered and apparently unrelated functions; yet a simultaneous disturbance in this group of functions occurs with a frequency that must have some significance. Furthermore, these disturbances of function can create a behavior so annoying to parents, teachers and others, and can, as a result, call forth reactions and counteractions of such a kind that a full-fledged orthodox "behavior problem" situation is at hand. Parental and teacher resentments, rejections, preferences, antagonisms, indulgences, overprotections, etc., human though they are, constitute an integral part of most "behavior problems."

PATHOLOGICAL LOCALIZATION

Pathological localization of the morbid process in these milder forms of encephalitis is naturally difficult and as yet largely speculative. It is generally thought that a virus passes through the cribriform plate and, because of proximity, invades the basal gray matter. There seems to be some affinity for basal nuclear structures, as seen in the frequency of Parkinsonian sequelae. But the most convincing evidence is found in the emotional changes (explosive rages, etc.); sleep disturbances (insomnia, reversals, narcoleptic conditions); metabolic and growth changes related to the hypophysis and hypothalamus; extrapyramidal motor signs (choreiform restlessness and incoördination); water metabolism disturbances; etc. I think Cushing's[15] work has definitely localized most of these functions around the third ventricle, in the hypophysis and adjacent gray matter.

CEREBRAL TRAUMA

There is a striking similarity between the above changes and those following cerebral trauma, as indicated before. This has been noted by numerous observers. Not many, however, have attempted to localize the actual pathology underlying this group of behavior changes. Friedman[17] has visualized definite organic changes in the encephalogram of head injuries, without attempt at localization. Blau[16] suggests a localized lesion of the prefrontal association area, but does not overlook the actual pathological "core" which is a disturbed integration or a dissociation between the higher and lower cerebral levels. He, furthermore, recognizes the importance of the subcortical ganglia in the "system of instinctual drives and motor impulses which form the basis of behavior." In our experience clinical evidence certainly points to a dissociation of the higher and lower levels of cerebral function, and with a striking frequency to the direct involvement of the so-called primitive brain (in both postencephalitic and posttraumatic behavior disturbances) because of accompanying neuro-vegetative and neuro-endocrine symptoms.

MILDER FORMS

Most studies heretofore have not dealt with the milder degrees of such disturbances. The absence of immediate and gross neurologic sequelae has apparently caused the investigator of later behavior difficulties to lose sight of the primary insult. Thus Kaiser and Zappert,[3] although they mention headache, confusion, instability and irritability, minimize these in their search for neurologic signs. Healy,[18] in the case of lethargic encephalitis, makes the following points: the severity of the initial infection is not an index of the severity of the sequelae; the age of onset has no direct relationship to the appearance of symptoms—there may be a long "latency period" up to puberty; there is no correlation between the neurologic signs and the severity of the behavior disturbance, between the severity of the illness and the effect on intellectual function; the disease is frequently overlooked due to mildness of onset and difficulty of early diagnosis. He, furthermore, says, "It may well be that the cause of not a few difficult careers is encephalitis," and, "Does this disease offer a possible etiologic explanation for at least some pathologic personalities, and in part for the hyperactivity shown in such a large proportion of delinquent children?" A careful early health history often reveals (to the parents) noticeable changes in growth, rate of development, self-control, emotional response, resistance to fatigue, etc., following one of the infectious diseases or a blow to the head with varying degrees of unconsciousness. The age of puberty may later bring out a rapid increase in weight, fainting spells, increasing sluggishness and disinterest, etc.

SEVERE FORMS

The more severe forms of postencephalitic behavior disturbance, like Hall's[10] "Apache" group or Bond's children, are soon recognized as such and constitute a known problem in itself. The underlying mechanism is considered by most ob-

servers to be a lifting of the inhibitions exercised by the higher centers over the lower, whether this be a prefrontal lesion, an interruption of certain tracts between the neocephalic and paleocephalic levels (Bonhoeffer[9]), destruction of some integrating structure, or whatnot. There is an impairment of the physical counterpart of Freud's "censor," or of the controller and regulator of civilized behavior. The clinical picture is a well-defined entity. The milder forms, however, corresponding to Hall's "difficult child" group, may never be recognized for what they really are, and may develop into classical orthodox "behavior problems," according to the reactions their behavior calls forth from the environment. A restless, distractible, uncontrolled child meets rejection, repression, and severity. He develops rebellion, insecurity, inferiority, and a long train of undesirable compensatory behavior is let loose. Equipped as he is with a poorly integrated nervous system, adjustment becomes increasingly difficult. Almost as destructive to his adjustment are anxiety and overprotection on the part of the parents. Distractibility and scattering of attention lead to difficulty in school; pressure by the parents makes matters worse. Poor coördination prevents adequate competition in play. And so the destructive chain of events might be endlessly prolonged. Although the neural damage of the encephalitis was the starting point of the difficulty, it is the interplay of multiple factors that creates the ultimate problem. On the other hand, we have been too prone to be sidetracked by these later and more apparent factors in the problem, have overlooked or insufficiently appraised the starting point, and have thereby neglected some important methods of treatment.

PITUITARY AND HYPOTHALAMIC DISTURBANCE

Mention was made of the relative frequency of pituitary and hypothalamic disturbances in this syndrome. This has both a diagnostic and a therapeutic implication—diagnostic in so far as it tends to localize pathology in the basal gray matter or primitive brain, therapeutic in that it gives clues to aids in treatment. Ten per cent of these children show one or more of the following: disturbances in water balance in either direction: enuresis or polyuria; increased sugar tolerance with a flat sugar tolerance curve; fatigability in the absence of other demonstrable cause; tendency to obesity and Froelich's syndrome; craving for sweets and other carbohydrates; vasomotor disturbances; deficiency of thyroid or gonads. These signs are, of course, merely indicative rather than conclusive.

MEDICAL TREATMENT

A medical treatment which we have found successful in many cases is directed chiefly toward sedation of the autonomic centers and pituitary stimulation. Small doses of phenobarbital, morning and evening, have caused an unlooked for improvement in restlessness and irritability. Massive doses of whole pituitary have caused an increased feeling of well-being, greater resistance to fatigue, a tendency to normalization of weight, frequent lessening of enuresis, regulation of menstrual disturbance, etc. All other physical conditions found are, of course, also treated as required. The hopes implied in this procedure may sound too sanguine. In dealing with the physical and mental problems of children, one can never discount the influence of ordinary growth and maturation in the direction of normality; we probably take credit for many good results that would have come anyway. Furthermore, it must be understood that medical treatment alone is rarely, if ever, efficacious—no more so than is it valid to consider the encephalitis the sole cause of the behavior disturbance. Along with medical treatment must go all necessary social treatment. Parents and teachers are required to accept this child as a handicapped child, and intelligently adapt their expectations to his capacity. Parents must be helped to change their destructive attitudes, be they plus or minus. Adequate rest periods and interruptions of sustained effort are instituted. Legitimate satisfactions are provided to replace undesirable compensations. Curricular adjustments are made. Foster home or institutional placements are made when necessary, and many other forms of social treatment may be called into play. Yet all these procedures can often be made easier and more efficacious if the marked tension surrounding the problem is broken into at some such point as is afforded by adequate medical treatment. When a child begins to be less hyperactive and irritable, sleeps and eats better, can concentrate for longer periods of time, the tension is eased and subsequent treatment can more adequately proceed.

SUMMARY AND CONCLUSIONS

Many behavior problems have their origin in the childhood infectious diseases, especially when complicated by encephalitis, and in cerebral trauma, whether during[19] or after birth. The milder degrees of these frequently go unrecognized until the child's behavior brings him into conflict with his environment. As a result of neural damage, these children become hyperkinetic, irritable, distractible, uncontrolled and aggressive. The reaction of adults to this behavior soon creates a problem situation. Besides the history of personality changes after the infection, examination shows choreiform restlessness, poor coördination, hyperactive reflexes and various signs referable to the hypophysis and hypothalamus. Disturbances of sleep and metabolism may be present. These findings indicate that the pathology is localized in the basal gray matter and hypophysis. Medical treatment directed toward autonomic sedation and hypophyseal stimulation may be successful in quieting and stabilizing the child. This eases the surrounding tension and makes subsequent social treatment more efficacious. Childhood infectious diseases should be carefully watched for signs of encephalitis.

Our experience with this group of cases reemphasizes the need of comprehensive study of every behavior problem from all angles. While it is true that adverse environmental situations call forth undesirable behavior in a given child, it is also true that flaws in the machinery of behavior lead to trouble even in a not too unfavorable environment. These flaws can go unrecognized for

years, but can be brought to light through careful history taking and adequate neurological and endocrine study.

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CHIROPRACTIC PRACTICE ACT OF CALIFORNIA†

DECREE OF THE SUPERIOR COURT OF SAN FRANCISCO, DATED OCTOBER 6, 1938

In the Superior Court of the State of California in and for the City and County of San Francisco
No. 257,362

In the Matter of the Application of M. James McGranaghan, for Declaratory Relief, Plaintiff, vs. Dora Berger, Intervenor and Defendant, vs. Roy G. Labachotte, Intervenor and Defendant, vs. The People of the State of California,* Intervenor.

† For a Proposed Chiropractic Initiative Law, see page 480. Also, see letter item on page 479.

* U. S. Webb, Attorney-General, Lionel Browne, Deputy, 640 State Building, San Francisco, California, Attorneys for Intervenor, the People of the State of California.

JUDGMENT

The above-entitled cause came on regularly for trial on the first day of June, 1935, before the Court, sitting without a jury, M. James McGranaghan, plaintiff and petitioner, appearing in *propria persona*, Roland J. White, Esq., appearing as attorney for intervenor and defendant Dora Berger, Frank V. Kington, Esq., appearing as attorney for intervenor Roy B. Labachotte, and U. S. Webb, Attorney-General, and Lionel Browne, Deputy Attorney-General, appearing for intervenor, the People of the State of California, and evidence, both oral and documentary, having been introduced, and the cause submitted for decision, and the Court heretofore made and caused to be filed herein its written findings of fact and conclusions of law, and the Court being fully advised:

Wherefore, by reason of the law and the facts found as aforesaid, it is ordered, adjudged, and decreed:

That M. James McGranaghan, petitioner herein, is a graduate of the National College of Chiropractic of Chicago, Illinois.

That the above-named M. James McGranaghan, Dora Berger, and Roy G. Labachotte, together with a large number of other persons, are chiropractors duly licensed under the laws of this State relating to the practice of chiropractic.

That it is true that an actual controversy exists between the parties to this action, and between divers persons licensed as chiropractors under the provisions of the Chiropractice Act of California, Statutes 1923, Chapter 88, and between chiropractors and drugless practitioners licensed under the provisions of the Medical Practice Act, Statutes of 1913, Chapter 354, and between chiropractors and physicians and surgeons, as to the scope of practice authorized under the provisions of Section 7 of the Chiropractic Act of California.

That it is necessary, to prevent continued conflict and controversy now existing, that the provisions of Section 7 of the Chiropractic Act of California be precisely construed.

That it is true that the petitioner is entitled to a precise construction of Section 7 of the Chiropractic Act of California, and to have a declaration of his rights and duties as a licensee thereunder in order to remove the danger of criminal prosecution for exceeding his authorized scope of practice, and to remove grave danger of jeopardy in the event of civil action for negligence in the use of measures outside his authorized practice.

That the People of the State of California, an intervenor in the above-entitled cause, is an interested party for the purpose of having an interpretation and construction of the said Section 7 of the Chiropractic Act of California.

That Dora Berger is licensed under the provisions of the Chiropractic Act of California, Statutes 1923, Chapter 88; that her interests are adverse to the plaintiff and that the scope of her practice may be materially affected by the determination of this action.

That Roy G. Labachotte is licensed under the provisions of the Chiropractic Act of California, Statutes 1923, Chapter 88; that his interests are adverse to the plaintiff and that the scope of his practice may be materially affected by the determination of this action.

That the phrase "materia medica" is a Latin phrase and not of the English language, but that it is a phrase of such common and well-known meaning that its use is not in violation of the Constitution of the State of California.

That it is not true that at the time of the adoption of said Chiropractic Act, or for any time prior thereto, any of the following subjects were or had been taught as chiropractic in chiropractic schools or colleges, to wit: anatomy, embryology, physiology, chemistry, toxicology, histology, pathology, neurology, bacteriology, physical diagnosis, laboratory diagnosis, nerve tracing, symptomatology, special technique including replacing shoulder, hip, rib, and foot subluxations and dislocations, obstetrics, gynecology, pediatrics, first aid and minor surgery, terminology, hygiene, sanitation, treatment of diseases of the eye, ear, nose and throat, diatetics, psychiatry, x-ray, jurisprudence, mechanotherapy, massage, medical gymnastics, hydrotherapy, colonic therapy, physiotherapy, electrotherapy, phototherapy, and practice building; that it is true that at the time of the adoption of said Chiropractic Act, and for a

long time prior thereto, the following subjects were taught as chiropractic in chiropractic schools or colleges, to wit: chiropractic, which is hereinbelow defined; chiropractic technique, which is the adjusting, in accordance with the theory of chiropractic, of the segments of the spine by hand when vertebrae are misaligned; spinal diagnosis or analysis, which is the method, according to the theory of chiropractic, of ascertaining the relation of the various vertebrae of the body to each other, for the purpose of ascertaining whether there is a misalignment of vertebrae which causes interference with the transmission of nerve force, and palpation, which consists of exploring and feeling the body over the spine to ascertain, by feeling, the relation of the various vertebrae to each other.

That it is true that chiropractic consists solely and not otherwise with the manual adjustment of subluxations and misalignments of the segments of the spine, when such subluxations or misalignments cause occlusions of nerve and interference with the transmission of nerve force at or within the spinal column.

That it is true that the Chiropractic Act authorizes licensees to use necessary mechanical, hygienic and sanitary measures incidental to the care of the body, but that such necessary mechanical measures consist of any appropriate means, method, device or apparatus for the sole purpose of ascertaining whether or not there exists in the patient an interference with the transmission of nerve force or energy at or within the spinal column, including the chiropractic hammer, chiropractic table, x-ray and neurocolometer, but not excluding similar means, method, device or apparatus hereafter developed or discovered, for the sole purpose hereinbefore mentioned; that such hygienic measures consist of the cleansing of the exterior surface of the patient's body over and adjacent to the spinal column by means of water, soap or other and similar means, but wholly without the use of drugs, medicines, or medicinal preparations; and that such sanitary measures consist of the use of clean sheets, clean pillow cases or covers, clean towels, clean gowns or other covering for the protection of the outer surface of the patient's body from contamination, contagion or infection, or communicable disease; that the use of such mechanical, hygienic and sanitary measures is permitted to a chiropractic licentiate and that such measures do not encroach on the field of medicine, as defined in Sections 8 and 17 of the Medical Practice Act, now Business and Professions Code, Sections 2137, 2138, 2139, 2140, and 2141.

That it is true that all practices or measures, except those enumerated in the foregoing paragraphs are exclusively within the scope of practice of a license holder holding either a physician's and surgeon's or a drugless practitioner's certificate issued pursuant to the provisions of the Medical Practice Act, or the Osteopathic Act of the State of California.

That it is true that any practice by a chiropractor in excess of that authorized by the Chiropractic Initiative Act is detrimental to the health, safety, welfare and well-being of the licensed chiropractors and of the People of the State of California.

That chiropractic as taught in chiropractic schools or colleges at the time of the adoption of the said Chiropractic Initiative Act was then and is now: The manual adjustment of subluxations and misalignments of the segments of the spine, when such subluxations or misalignments cause occlusions of nerve and interference with the transmission of nerve force at or within the spinal column. That the only necessary mechanical, hygienic and sanitary measures incident to the care of the body permitted a licentiate are the chiropractic table, chiropractic hammer, towels and other instrumentalities which do not violate the provisions of the Medical Practice Act, the Osteopathic Act, the Dental Act or the Optometry Act, and which do not involve the use of any drug or medicine included in materia medica.

That all methods of treatment, save and except those which are chiropractic and which relate to chiropractic sanitation and chiropractic hygiene, constitute the practice of medicine, surgery, osteopathy, dentistry, and optometry.

That x-rays, spinagraphs or roentgenograms of the spine only may be made and taken by chiropractors for the purpose of making a chiropractic diagnosis or analysis of the spine only, but that any other use or treatment by means thereof is prohibited to chiropractors and is definitely included in the practice of medicine, surgery, dentistry and optometry.

That all practices or the use of any measures in excess of those specifically enumerated as being within the scope of practice of a licentiate in chiropractic in the State of California are not permitted to and are not authorized as to chiropractors, and particularly petitioner McGranaghan and intervenors Labachotte and Berger.

Wherefore, it is further ordered, adjudged and decreed that the intervenors Dora Berger, Roy G. Labachotte and The People of the State of California, do have and recover of and from the plaintiff and petitioner, M. Jas. McGranaghan, their respective costs and disbursements incurred in said action, with interest thereon at the rate of seven per cent (7 per cent) per annum from the date hereof until paid, in the respective sums of Dora Berger, ——— dollars ($———); Roy G. Labachotte, ——— dollars ($———); The People of the State of California, ——— dollars ($———).

Dated this sixth day of October, 1938.

JOHN J. VAN NOSTRAND,
Judge of the Superior Court.

THE LURE OF MEDICAL HISTORY†

PLAGUE EPIDEMICS IN SAN FRANCISCO: HISTORICAL NOTES

By GEORGE H. EVANS, M.D.
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PART II*

A PERIOD of apparent security followed the epidemic of 1900 and 1901. The federal health authorities had confined the disease to the limited area of Chinatown and had made a good job of cleaning up this noisome quarter. Plague and its dangers ceased to confront the populace. Many still believed it had never existed.

RECRUDESCENCE OF PLAGUE IN 1906–1907

Even those who realized the potential dangers of further outbreak, as they looked over the four square miles of desolation following the fire of April, 1906, felt that all possible foci of infection which might have remained were thoroughly sterilized now. Pestilence could not rear its head in these areas so thoroughly disinfected by fire. All attention could now be concentrated in rebuilding San Francisco. To this all other interests must be diverted. In the hurry of rehabilitation, San Francisco neglected its opportunity of remaking a city which would present to the world a model in hygiene, architecture, and city planning. Burnham plans were impatiently cast aside; the dream of the city beautiful, the city free from structural defects which invite pestilence was ignored, and everything was subordinated to the immediate task of rehabilitation. This policy was soon to be reflected in the recrudescence of plague, which again occurred in 1907 and 1908.

† A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

* In three parts. Part I appeared in the November issue, on page 383.

Those of us who tramped over this area of "damndest finest ruins," in the ensuing few months as rebuilding got under way, will never forget the scene of desolation. Thousands of homeless people had to be housed in wooden shacks, many built on the débris of previous buildings. The earthquake had broken the sewers in many places and there was scarcely a lot in the burned area which did not have an exposed place for the ready ingress and egress of rats, which freely used this subterranean labyrinth for their migration throughout the city in search of food.

LARGER AREA INVOLVED IN THE SECOND OUTBREAK

All the conditions essential for a widespread recrudescence of plague, therefore, existed, and it was not surprising that in May, 1907, a sick man was taken to the United States Marine Hospital, where he died of plague. No other cases were discovered until August 12, but in the month of August fourteen persons came down with the disease in areas widely scattered throughout the city. The following month, when fifty-five cases of plague had been discovered, Mayor Taylor appealed to Washington for help, and Dr. Rupert Blue of the Public Health Service was sent to San Francisco. While a systematic campaign against the rat population was at once inaugurated, no one knew better than Doctor Blue that, despite all the efforts of his able group of assistants, success could not be attained without general popular coöperation. The experience gained from many epidemics in the Orient had abundantly demonstrated that, unless a determined effort to starve the rats out of a community is undertaken, trapping and poisoning alone has little effect upon the rat population. Propagation exceeds the mortality caused by trapping and poisoning. In Tokyo it had been found that after destroying four million rats the breeding rate increased as the struggle for existence among the rats was relieved.

Those of us who knew Doctor Blue and were familiar with his problem will remember the discouragement caused by his ineffectual efforts to obtain any coöperation from the San Francisco press. As in the 1900 epidemic, "big business" refused to accept the evidence that plague existed, and though confronted with the danger of a federal quarantine (for now that the epidemic was scattered throughout the city, it was no longer confined to Orientals), the press, despite the urge of Doctor Blue and Dr. William Ophüls, President of the San Francisco Board of Health, refused to "unnecessarily alarm the public," though public coöperation could only be obtained by publicizing the facts.

PART TAKEN BY THE CALIFORNIA MEDICAL ASSOCIATION

This was the situation at the end of 1907, when the Medical Society of the State of California, as the California Medical Association was then known, recognizing its responsibility to the people in a matter of grave public health emergency, decided to actively participate in an effort to arouse an uninformed public and make them plague-conscious to the impending danger. The president of the State Medical Association* had observed with alarm the steady increase in infection among the rats trapped and poisoned. In six months rodent infection had increased, without remission, from approximately one-half per cent to one and one-half per cent. It had reached a point where, from the experience in epidemics elsewhere, an increase in human infection was inevitable. While human infection had not as yet materially increased, this was due to seasonal variation. There is invariably a recession in human infection during the winter months.

The matter was presented to the California Medical Association Council by the president of the California Medical Association, and at his request a committee was appointed, consisting of Doctors Harry M. Sherman, John Gallwey, John M. Williamson, James H. Parkinson, and the president of the society [Dr. George H. Evans] acting as chairman. The result of the activities of this committee was the formation of the Citizens' Health Committee, a campaign of publicity and education, and by a concentration of power and authority in the hands of a devoted group, willingly accorded by a public now conscious of the danger which threatened, a few short months were sufficient to bring the work to a successful conclusion.

THE PLAN OF THE STATE MEDICAL ASSOCIATION COMMITTEE

The committee of the State Medical Association immediately organized and considered its plan of campaign. It was at once apparent that, without publicity, nothing could be done to avert disaster. It was, therefore, first decided to call a mass meeting of representative citizens to which six hundred invitations were issued, and that at this meeting a resolution should be presented urging the formation of a citizens' health committee of twenty-five members, to be appointed by the mayor, consisting of thirteen laymen and twelve physicians, the latter composed of names presented by the president of the State Society.

THE PUBLIC MEETING

The meeting was held, but with only sixty persons responding to the call. Present on the speakers' platform were the mayor, the president of the San Francisco Board of Health, Dr. Rupert Blue, and the members of the State Society committee under whose auspices the meeting was called. Though disappointing in numbers, those present were earnest citizens seeking facts regarding plague. These were forcefully presented by the speakers, and when Doctor Gallwey presented the resolution calling for the appointment of a Citizens' Health Committee there was no dissenting voice. The two great mercantile organizations, the Merchants' Association and the Chamber of Commerce, through their officials present, pledged their full support and coöperation.

* Editor's Note.—The president of the State Medical Association at that time was the author of this paper, Dr. George H. Evans.

CITIZENS' HEALTH COMMITTEE

The next day the mayor appointed the committee, which promptly organized and named an executive committee, consisting of Charles C. Moore (chairman), Walter MacArthur, Gustave Brenner, A. W. Scott, Jr., and Dr. George H. Evans.

The next public assembling was a mass meeting held on the floor of the Merchants' Exchange on January 28, 1908, with several hundred present. The Governor of the State emphasized the gravity of the situation; Doctor Blue drew a picture of what a federal quarantine meant; prominent state and city officials pledged coöperation with and support of the Citizens' Health Committee. The popular movement was launched.

THE COMMITTEE'S TASK

The Executive Commitee, on which devolved the problem of education and publicity, realized at once the enormity of the task confronting it. Rats must be destroyed, not only by trapping and poisoning; they must be starved and built out of the city. There must be general destruction of rat-harboring places throughout the city, and there must be no food left accessible to a rat. This meant the passing of radical statutes compelling rat-proofing of all structures containing food, the demolition of all buildings such as stables, slaughter-houses, etc., which could not be made impervious to rats. It meant the destruction of the many floored back yards of San Francisco where rats could nest. It meant that no food nor garbage could exist in the city where a rat could have access to it. It will at once be seen that such results could only be obtained by the complete coöperation of every portion of the population. Rigid sanitary inspection must be made in every home and place of business. Consequently, the first step must be the formation of subcommittees of citizens in all lines of business and social activity, whose duty it would be to arouse all those within their spheres of activity to the importance of coöperation. This was done by personal contacts, much printed instruction, and addresses to large groups. The interest of the school children was obtained through talks on general hygiene and rat destruction. So successful was this propaganda on the receptive minds of these youngsters that woe betide the housewife if one of her children should find the garbage can uncovered on his return home from school.

COMMITTEE'S POWER: "GOVERNMENT BY DECREE"

It was found necessary to enact rigid ordinances covering effective rat-proofing, with severe penalties attached for any infraction thereof; and as the ordinances were formulated by the Executive Committee they were sent to the Board of Supervisors with instructions to pass them without delay. If this was "government by decree," the emergency was urgent and justified its exercise.

TRIBUTE TO LATE C. C. MOORE

To carry through its work it was essential that the Executive Committee should have leadership. It is fitting at this time, therefore, that tribute should be accorded to the chairman of the committee, the late Charles C. Moore, whose active citizenship is now but a grateful memory. He was a great citizen, forceful and efficient, yet tactful and diplomatic, an inspiration to his committeemen when, during the stress of the daily arduous duties, sometimes sheer exhaustion threatened energy and efficiency. In his daily talks to the various industrial committees he was earnest and convincing, though sometimes it was found necessary to scold and threaten the skeptical and obstinate. I well recall a meeting with a small group of machinery manufacturers. In explaining to them the effect of a federal quarantine, he took occasion to say, "Probably you do not realize what such a quarantine means. It means that each man in this room, and you are all millionaires, will go broke."

These meetings with the representatives of the mercantile and social activities of the city were daily addressed by the members of the Executive Committee, 162 such meetings being held in a period of six weeks' time.

FINANCIAL NECESSITIES

It was soon apparent to the committee that the appropriations from the Federal Government and the San Francisco Board of Health were inadequate to carry on the work, which had assumed such large proportions. At one time there were 919 men in the field—inspectors, rat catchers, and laborers. Early in February it was decided to appoint a Finance Committee to raise a sum of $500,000. That such a large amount did not prove necessary was due to the splendid coöperation of the citizens generally through the cleaning of their own premises. The amount actually collected, largely through assessment of the business and social groups, was $177,512, of which 19 per cent was returned at the end of the campaign. These assessments were levied in proportion to the estimated financial status of the groups assessed, and in almost all instances the assessments were considered just. It is interesting to observe that where argument was necessary to convince the reluctant, the fear of federal quarantine proved more potent than the danger of plague.

HOW APPOINTMENTS WERE MADE

In order to avoid any charge of political appointment the committee made no appointments, though pressure was frequently brought upon it, sometimes through some of the largest subscribers to the fund. All appointments were made by the federal authorities through Doctor Blue.

INCIDENCE OF PLAGUE IN THE 1907 OUTBREAK

The total number of human cases from the inception of the epidemic in May, 1907, was 160, the last one having occurred in February, 1908; but it was not until October that the last infected rat was found.

78 The Uplands.

(To be concluded)

CLINICAL NOTES AND CASE REPORTS

HYDRATION MADE EASIER

By JOSEPH E. TILLOTSON, M.D.
Colusa

PRIMITIVE man, stricken ill, received liquids in containers which nature provided — coconuts, gourds, eggs of the larger birds, shells and the human skull.[1] In the seventeenth century we find evidence of thought for his comfort in Green's list of 1668[2] . . . "fountain pots for refreshment by suction, the 'spout pots' for the same service by old people and invalids." Since then refreshment by suction has taken various forms, *i. e.*, the soft-drink straw. But for bedridden patients who may consume hot liquids as well as cold, the glass tube is used, crooked for convenience.

A step further in consideration of the patient's comfort and needs, and at the same time minimizing nursing attention, is the use of a long rubber tube connecting two conventional hospital glass drinking tubes. The patient has but to move his arm or hand to secure the means of alleviating his thirst. The accompanying drawing illustrates this drinking tube. The inset shows its component parts: two glass tubes and rubber tubing.

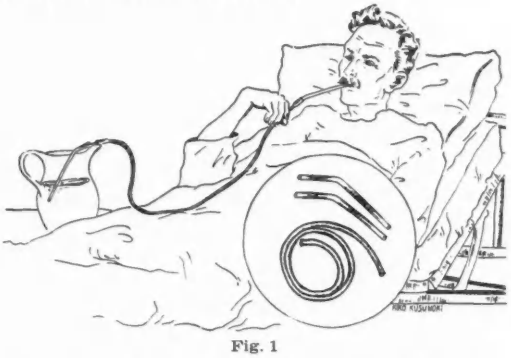

Fig. 1

By way of summary may be mentioned that constant need for fluids is made easily available. Important nursing care is accomplished with minimum nursing effort; where nursing facilities are limited, as in large wards, patients are self-contained in procuring fluids. Pneumonia patients, for instance, and others extremely ill and in dire need of fluids, find such requirement covered with conservation of their depleted energy.

Colusa Memorial Hospital.

MINERAL OIL AS A LAXATIVE*

By JAMES W. MORGAN, M.D.
San Francisco

THERE is perhaps no drug which has attained such a wide and universal currency for this purpose in the civilized world of today. Its acceptance is based on the belief that mineral oil is a bland and innocuous intestinal lubricant, while the numerous and considerable deleterious effects which may follow its continued administration have failed to be recognized.

In this paper attention will be drawn to the effects of mineral oil in disturbing normal physiologic processes, as well as to the pathologic changes which may attend its use.

The texts on pharmacology suggest no rational therapeutic basis for the use of liquid paraffin, the chemistry of which is, to say the least, uncertain.

The rectum is not a reservoir. Functionally it is but a short passage to the exterior.

The use of mineral oil as a laxative is open to severe criticism on the ground that it destroys the normal physiologic processes.

When mineral oil is present in the rectum complete evacuation is impossible.

The use of mineral oil was shown to be the cause of weight loss in children by Till and Dutcher.

Mineral oil, whether or not it is in complete emulsion, hastens the motility of the bowel contents in the small intestine and, as a consequence, digestion is incomplete.

There is clinical evidence that individuals who have taken oil over a long period of time suffer from "indigestion."

Mineral oil should never be given before or after operations on the rectum.

The use of mineral oil is often an indirect cause of pruritus ani.

Channon and Collinson proved that oil is absorbed from the gut and that it appeared in the livers of rats and pigs.

SUMMARY

A. *Physiologic Considerations:*

1. Mineral oil lubricates the rectosigmoid and makes a reservoir of the rectum.

2. Mineral oil makes complete evacuation impossible.

3. Mineral oil has a very deleterious effect on the nutritional economy of fat-soluble vitamins.

4. Mineral oil hastens the motility of the bowel contents and thereby prevents complete digestion.

5. Mineral oil may interfere with the process of absorption throughout the bowel.

B. *Pathologic Considerations:*

1. Mineral oil interferes with the healing of postoperative wounds in the anorectal region and may induce hemorrhage.

2. Mineral oil is often the indirect cause of pruritus ani.

3. Evidence is accumulating that mineral oil may be absorbed, producing pathologic changes in the liver and other abdominal viscera.

[1] Encyclopedia Britannica, 14th Edition, 7:663, 1929.
[2] Hartshorne, Albert: Old English Glasses, Edward Arnold, 1897.

*NOTE.—The first paper from the Phelan Fund of the University of California, "For the Improvement of the Comfort of the Bed-Ridden Patient," appears in the November issue of the *American Journal of Surgery*. The title is "Misgivings on Mineral Oil as a Laxative" and it is written by Dr. James W. Morgan, Instructor in Surgery, who, with Dr. J. B. deC. M. Saunders, was selected by Dean Langley Porter to do the research work.

CONCLUSIONS

The internal administration of mineral oil, either alone or in combination with other substances, may be attended by decided disadvantages. In view of the light-heartedness with which mineral oil has been prescribed as a laxative, I feel that this discussion is timely.

Fitzhugh Building.

INTRACRANIAL TUMORS

By HANS VON BRIESEN, M.D.
Los Angeles

IT has been well brought out that although few brain tumors are malignant, in the pathological sense of forming metastasis to other parts of the body, all of them are malignant in the sense of morbidity and death.

We know little of their etiology or prevention. Therefore, the first problem is a recognition of a tumor, and the second is its localization. That this last is difficult may be illustrated by several cases.

REPORT OF CASES

CASE 1.—This case was clinically a frontal lobe tumor. By "clinically" here is meant history and bedside examination. Figures 1 and 2 show internal hydrocephalus, and rule this out. Figure 3 shows erosion of the bone about the left internal auditory meatus, and with vestibulary tests establishes the diagnosis of left cerebello pontile angle tumor.

* * *

CASE 2.—This case was clinically a right cerebellar tumor. Ventricle studies, Figures 4 and 5, ruled this out, and we found we were dealing with a right cerebral tumor.

* * *

CASE 3.—This case could not be localized clinically. Study of the x-ray plates, Figures 6 and 7, shows a parasagital meningioma.

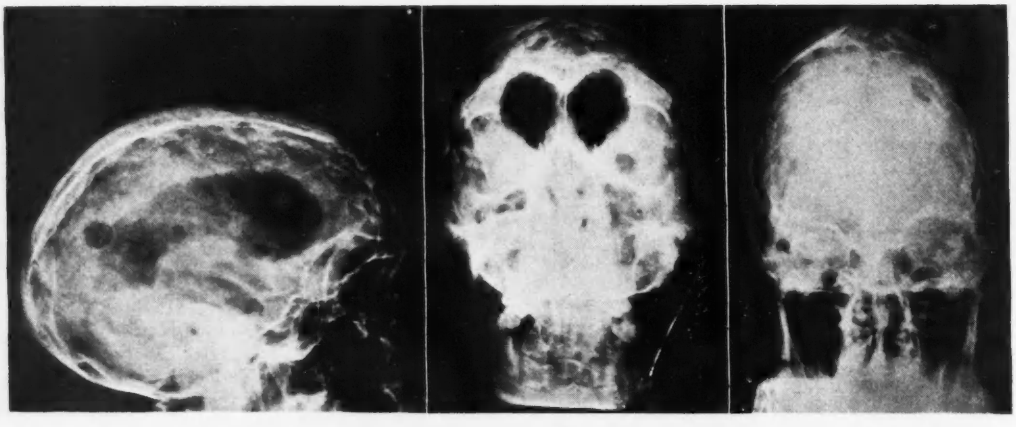

Fig. 1 Fig. 2 Fig. 3

Fig. 1.—Lateral encephalogram of Case 1 showing internal hydrocephalus.

Fig. 2 (Case 1).—Anterior posterior encephalogram showing internal hydrocephalus and with Fig. 1 ruling out bedside diagnosis of frontal lobe tumor.

Fig. 3 (Case 1).—Anterior posterior routine skull picture, showing erosion of left petrous bone, about the internal auditory meatus.

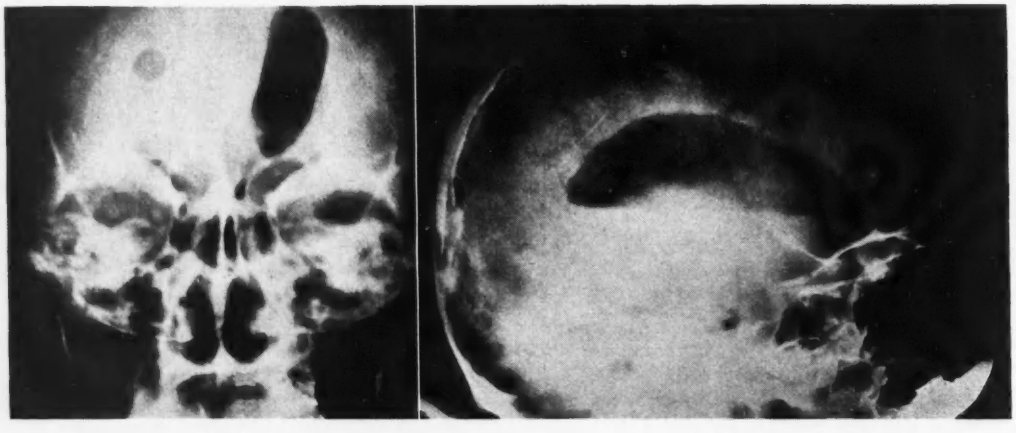

Fig. 4 Fig. 5

Fig. 4 (Case 2).—Obliteration of the right lateral ventrical, ruling out bedside diagnosis of cerebellar tumor.

Fig. 5.—Lateral view of Case 2.

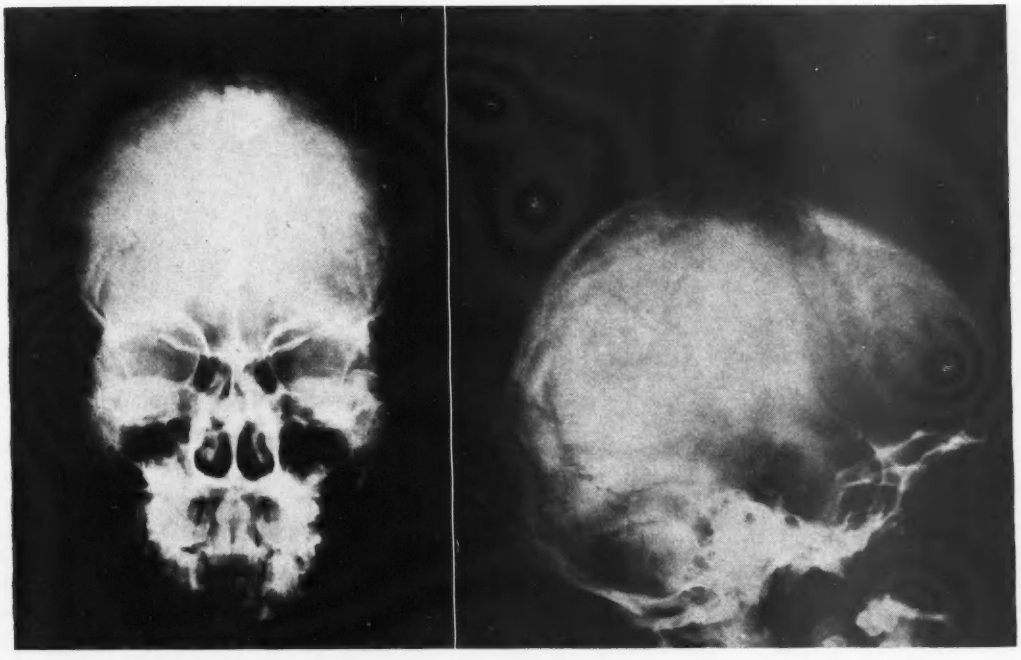

Fig. 6 Fig. 7

Fig. 6 (Case 3).—Anterior posterior routine x-ray of case which was impossible to localize clinically, showing calcified meningioma high in the midline.

Fig. 7 (Case 3).—Lateral view showing thickening of skull and calcified tumor, at top of coronal suture.

CASE 4.—The x-rays of this case have been lost; however, they show a marked internal hydrocephalus, similar to Case 1. The clinical diagnosis was basilar meningitis, with obstruction. At postmortem we found we were dealing with a cystic astrocytoma of the cerebellar vermis that might have benefited greatly by surgery.

These cases have illustrated several points, and without explanation in detail they are stated.

First: No surgical attack, with removal in mind, should ever be made without complete examination, air studies, careful and meticulous study of the regular x-ray plates, and, where possible, perimetric studies and vestibular tests.

Second: After increased intracranial pressure has set in, the picture is clouded by false localizing signs.

Third: With brain tumors, patients too sick to be operated are cases in which surgery must be given every consideration. Desperately ill patients, who would certainly die if only supportive treatment is given, can sometimes be saved by surgical intervention, and although this may often transfer the death from ordinary to operative mortality in the records, it will tend to reduce case mortality, which, in the end, is what we strive for.

Fourth: In dealing with brain tumors the diagnosis, localization, and surgical interference should be accomplished at once; delay being fatal in many cases because the compensation of the brain to the tumor may fail at any moment.

TREATMENT

There is no adequate medical treatment. Stated simply, surgery and radiation are the only methods, and they attack the two factors which make the tumors dangerous, that is, growth and reaction.

PROGNOSIS

Recently, a well-known and courageous colleague made the inquiry, if it might not be true that a number of the cases salvaged by surgeons are not a matter of taking "scrap heap common," and making it "scrap heap preferred." Is this true in the treatment of brain tumors? If one recalls the number of successful cases, especially among the slower growing types, it is obviously not true. There are many of these patients who can be restored to normal, and the attempt to do so should be made in all of them.

1930 Wilshire Boulevard.

NEUROFIBROMA OF THE RECTUM

By MONTAGUE S. WOOLF, M.D.
San Francisco

ALTHOUGH visceral neurofibromata are not rare, a tumor of this nature in the rectum is excessively rare.

The commonest site of intestinal neurofibroma is in the wall of the stomach. It is usually designated as schwannoma in Continental literature, and is stated to arise from Schwann's sheath in Auerbach's plexus or from Raymark's fibers. The tumor may be mistaken for sarcoma, having a low grade of malignancy. It has no tendency to recur even after incomplete removal but, if left, may give rise

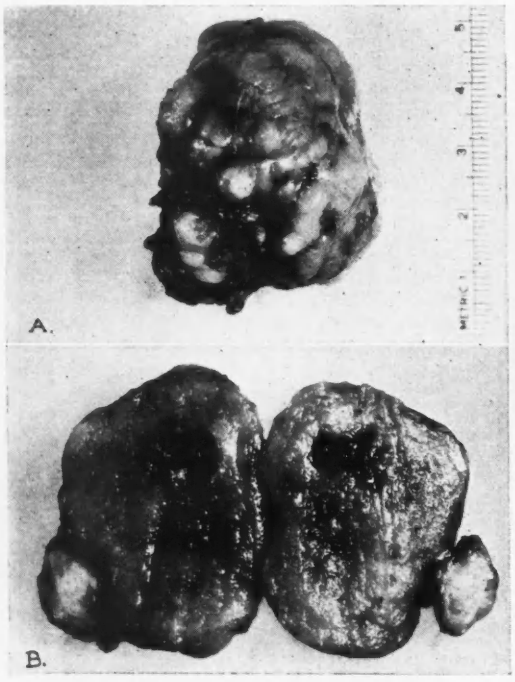

Fig. 1.—(A) Encapsulated neurofibroma. (B) Cut surface of A.

to widespread metastases in the liver. The location in the stomach is in the posterior wall.[1]

The mesentery may also be affected by a neurofibroma. In one case,[2] such a tumor, two inches in diameter, was formed of fibrous tissue with a nerve trunk running through it, causing pressure and distortion of the duodenum but no intestinal growth. If it occurs in the wall of the bowel, bleeding may result and blood be passed through the rectum.[3] In another case, "dozens of small white fibrous tumors about the size of millet seeds were seen all over the stomach," and "the vagi nerves were markedly affected from skull to stomach and at intervals had distinct fusiform swellings. The phrenic and sympathetics were similarly affected."[4]

Neurofibromata have also been described in the pharynx, gall-bladder, tongue, nose, and ureter.

REPORT OF CASE

J. F. McA, age seventy, went to a physician on account of dysuria and acute urinary distention, for which he was first catheterized three years previously. Later, during a digital investigation of his prostate, a rectal mass was discovered from which the patient had had no symptoms.

When he came under my care, a somewhat irregular mass was felt posteriorly, apparently between the rectal wall and coccyx. The examining finger could reach the upper limits. The mucous membrane was intact and moved within its normal range over the tumor. A biopsy was taken from within the rectum and pronounced to come from

1 Hosoi, K.: Neurogenic Appendicitis: Study of One Hundred Ninety-Five Cases of Appendicular Neuromas, Am. J. Surg., 22:428-446 (Dec.), 1933.

2 Dudley, G. S.: Visceral Neurofibroma, S. Clin. North American, 10:539-540 (June), 1930.

3 Cabot: Unusual Cause of Hematemesis (Case 18283), New England J. Med., 207:91-93 (July 14), 1932.

4 Shouldice, E.: Multiple Fibromata: Case with One Fibroma Enlarging Into the Stomach, Canad. M. A. J., 15:66-69 (Jan.), 1925. (Illustrated.)

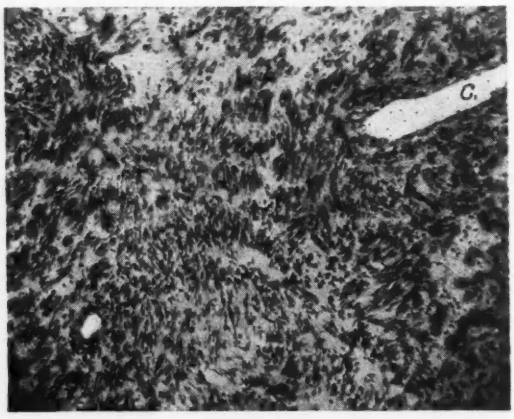

Fig. 2.—Microscopic section of neurofibroma, showing pallisade arrangement of cells.

a neurofibroma. A few days later the coccyx was removed and an encapsulated lobular firm tumor removed from within the rectal wall. Healing was uneventful. Before he left the hospital, Dr. Frank Hinman removed the prostate by the perineal route. The patient's convalescence from this was also uneventful.

Pathological Report, S. P. 35,1101:

Clinical Data. — Male, age seventy. Prostatism with hypertrophy of prostate. Tumor discovered during rectal examination. Posterior, not attached to mucosa, firm, slightly nodular.

Clinical diagnosis: Benign tumor.

Examination of Tissue. — Material: From retrorectal tumor.

Gross Description. — The specimen consists of roughly spherical, firm, coarsely lobulated, pale yellow-gray tumor mass, measuring 5.5 by 4.5 by 4 centimeters and weighing 35 grams. The tumor appears to be completely encapsulated by a thin fibrous covering. The specimen is accompanied by a small, one-centimeter nodule similar to the above. The cut surface is pale gray, contains a few small, smooth-walled cysts, and is made up of interlacing strands of fibrous tissue supporting a translucent gray tissue. Fixed in Zenker's and formalin.

Microscopic.—Multiple sections show the tumor to be made up of combed-out masses and cords of spindle-shaped cells, showing considerable palisading of the nuclei. A rare mitotic figure is found. PTAH stain shows considerable intercellular substance resembling collagen; and while many of the nuclei are spindle-shaped and show the square end resembling smooth muscle nuclei, the cells do not contain myoglia fibrils.

Diagnosis.—Neurofibroma.

384 Post Street.

PREGNANCY FOLLOWING OPERATION FOR CHRONIC INVERSION OF THE UTERUS

By HAROLD J. GREGG, M.D.
AND
FRED C. GREGG, M.D.
Calexico

WE believe that a case report of pregnancy with a normal full-term delivery, following an operation for chronic complete inversion of the uterus, will be of interest because of its rarity.

In 1927 Miller,[1] in his article on pregnancy following inversion of the uterus, reviewed fifty-five such cases collected from the literature up to that

1 Miller, N. F.: Pregnancy Following Inversion of the Uterus, Am. J. Obst. and Gynec., 13:307, 1927.

time, and added one case of his own. Of these fifty-six cases, twenty-three were corrected by operation. Since his report, a search of the literature reveals case reports of four other cases of pregnancy following operative procedures for correction of inversion of the uterus, making a total of twenty-seven cases.

We wish to add the following case to those already reported.

REPORT OF CASE

History.—Mrs. L. W., age twenty-seven, para II. Her first confinement, which occurred in 1930, was normal in all respects. The second birth, following normal pregnancy and delivery, took place approximately two years later in November, 1932. According to the history, as given by the patient, the duration of labor was eleven hours, with delivery of placenta one-half hour later, following hypodermic injection (presumably pituitrin), and exertion of considerable traction on the cord. No pressure was made on the fundus. At the time of delivery of the placenta, she experienced severe pain in the pelvis, followed by profuse vaginal bleeding. She remained in a semiconscious condition for six or seven hours, and was given several hypodermic injections and hypodermoclysis. Upon regaining consciousness she had considerable pain in the left lower quadrant for twelve hours, which was finally relieved by drugs. There was no evidence of sepsis during the puerperium, and the lochia was normal. The first intimation she had of any abnormality was when she arose on the eighth postpartum day, and felt a tumor protruding from her vulva. Her attending physician, who was called at this time, advised her of the nature of the condition, and told her an operation would be necessary later to correct it. During the following six months the uterus would protrude through the vulva with any straining, such as occurred during evacuation of bladder or bowels. Several months following her confinement, she had a vaginal hemorrhage induced by sexual intercourse, with bleeding continuing over a period of two days. Previous to that she had had slight vaginal bleeding, accompanying protrusion of the womb. Her child continued on the breast for a year and five months, with no establishment of menstruation until after the operation for correction of the inversion which was performed a year and six months following childbirth.

In February, 1934, she reported to us with the above history, seeking our advice as to treatment.

Findings and Treatment.—Examination revealed an easily bleeding mass about the size and shape of a completely involuted uterus hanging in the vagina. The fundus was not in its normal position. A diagnosis of complete chronic inversion of the uterus was made, and operation for its correction advised. A Spinelli operation was performed in March, 1934, consisting, briefly, of an anterior colpotomy with anterior median incision through cervix and fundus, followed by digital reinversion of the uterus with restoration of normal relationship between mucosa and serosa. The uterine incision was closed in the usual manner, the womb slipped back into the abdominal cavity, and the colpotomy wound was sutured. The postoperative course was uneventful, except for a slight hemorrhage on the sixth postoperative day. She remained in the hospital two weeks.

Course.—Examination one month later showed the uterus to be in its normal position and the cervical and colpotomy wounds healed. Five weeks postoperatively she had her first menstruation since confinement, which was normal in amount of flow and duration. She continued menstruating regularly until December 5, 1936. On September 7, 1937, she came to the office for an antepartum examination, with nearly a full-term pregnancy, the date of expectation being September 12. On September 11 she began losing amniotic fluid, and this continued in small amounts until her delivery on September 14 of a normal eight-pound child, following two hours of labor. The third stage of labor was characterized by a small hemorrhage, which was controlled by massage of the fundus and an injection of one-half cubic centimeter of obstetrical pituitrin. The placenta was delivered after fifty minutes, with the aid of slight pressure on the fundus and very gentle traction on the cord. The subsequent course was uneventful. Examination one month postpartum showed the uterus to be nearly completely involuted and normally anteverted with moderate retroplacement. Examination of the cervix by speculum showed it to be in good condition with no lacerations. There was a slight linear indentation on its anterior lip, indicating the location of the old operative scar.

COMMENT

There is a difference of opinion regarding the management of pregnancies following operation for correction of these cases.

Miller, in the article previously referred to, states that "the danger of ruptured uterus in subsequent pregnancies where the original lesion was corrected by operative means is greatly exaggerated." Other writers believe that cases that have had rather extensive operative procedures on the uterus itself should preferably be delivered by abdominal cesarean section. The only case reported of uterine rupture during a subsequent labor is that of Barrows.[2] This was a case for which a Spinelli operation had been performed for an inversion of the uterus ten days postpartum. Two years later the patient delivered a stillbirth, following twelve and one-half hours of moderate labor. Three hours later she went into shock, when a diagnosis of ruptured uterus was made, which, upon operation, was found to have a rent through the upper half of the old operative scar. Barrows reports that postmortem examination showed areas of calcification in the old scar, evidencing infection of the scar following the Spinelli operation.

It will be noted that since this case was originally operated on ten days postpartum, it would probably come under the heading of subacute inversion. We believe that infection of the uterine wound would be more apt to occur in such cases of subinvolution of the uterus than would be probable in cases following operation where complete involution had taken place.

It is our opinion, after a study of the literature concerning these cases, that conservatism in the handling of subsequent pregnancies is justified in most cases.

218 Dool Building.

2 Barrows, D. N.: The Treatment of Recent Puerperal Inversion of the Uterus, with a Report of Five Cases, Am. J. Obst. and Gynec., 27:105-108 (Jan.), 1934.

Medical Supplements in the Press.—Two county societies have recently collaborated in the publication of medical supplements in their local newspapers. On October 25 the Nassau County Medical Society, Mineola, New York, published a health section of forty-eight pages in the Nassau *Daily Review-Star* and on October 30 the Wayne County Medical Society, Detroit, published its second annual medical supplement in the Detroit *Free Press*. Both supplements were profusely illustrated and the editorial content was of a high order. Both were published in tabloid form with original front-page layouts, the Nassau society using an interesting arrangement of photographs and the Wayne County Society using an original drawing. Not only were the activities and functions of the local societies and the American Medical Association described in both supplements, but a wide variety of interesting articles on all phases of medicine and health were used. Such supplements, properly prepared—as these two were—provide an excellent medium of public education in matters vital to health of the individual.—*Journal of the American Medical Association*, November 12, 1938.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

THE ORIGIN AND TREATMENT OF ANORECTAL FISTULAE

I. SURGICAL ANATOMY AND PATHOLOGY

PAUL C. BLAISDELL, M.D. (102 North Madison Avenue, Pasadena).—We, as surgeons, are prone to skip over topics on pathogenesis for interest in the more practical aspects sought under "treatment." This might be a proper conservation of time and energy, did not a correct conception of pathogenesis at least occasionally hold some secret of, and thus predicate, adequate clinical care. Such is the case with rectal fistulae, and when one adds thereto the general lack of understanding of the anatomy involved he has rather complete explanation of commonly poor fistula surgery, as revealed by the cold facts.

Nearly all anal fistulae originate as infections in the crypts of Morgagni. This fact is not only of pathogenic, but also of surgical importance, for successful fistulectomy necessitates finding the internal opening which, in turn, is largely dependent on knowing where to look for it. To be exact, over 98 per cent of our own cases have been found directly traceable to crypts, and less than 2 per cent to posterior fissures. We have seen primary internal openings higher up only in connection with cases of lymphogranuloma inguinale and impalement injuries, both rare in private practice. Secondary openings, of course, may occur higher, due either to rupture of the antecedent abscess, or to injudicious probing or trauma.

Now in the human there have been demonstrated epithelial lined ducts, regarded as the remains of complex glandular organs found in rabbits and dogs, which open into the crypts and thus afford a ready path for infection from the crypts with their constant stasis of infected material, into the wall of the anal canal, or through it to the surrounding tissue. The sequence of events, then, in the formation of a fistula is stasis of fecal matter in deep and poorly drained crypts: infection of the blind ducts leading outward from the crypts with penetration through small defects in the epithelial lining of these ducts, and burrowing into the surrounding tissue to form an acute abscess. With the opening of the abscess either spontaneously or by incision, either through the skin or elsewhere in the mucous membrane, a complete fistula immediately exists from the internal opening to the point of opening of the abscess. This fistula fails to heal permanently because of constant reinfection from the rectum through the preformed tubules with their lining of epithelium: if it does heal temporarily the patient is subject to formation of another acute abscess with further extension of the fistula. Only complete operative eradication of the whole tract will effect cure.

Let us introduce now Exhibit "A," to see how well these simple facts of pathogenesis are understood in relation to their important practical application. We questioned forty consecutive patients at a large charity institution who had rectal fistulas, and who gave a history of having had the acute abscess (stage) incised by physicians, until we found one who had been warned by his physician that a fistula would, or even might develop, following the abscess.

That is, thirty-nine out of forty patients whose acute abscesses were incised, were dismissed by the operating physician, all assuming that they were cured and would have no further trouble, an impression the more easily given unwarranted credence because of the tremendous relief from pain following simple incision. But one patient, therefore, out of forty received adequate advice or treatment, and the true nature of the condition dawned upon all the rest only after months and years of continuous or recurrent difficulty with their residual fistulae. We say months and years: the average length of time between incision of the abscess and the operation for the fistula was four and six-tenths years!

Thus it is essential, we say, to understand the pathogenesis of anal abscesses and fistulas and their relation to each other; to appreciate that the former are entirely different entities than boils and superficial abscess elsewhere, and that simple incision never ends their story. It is a sad mistake to have four and six-tenths years of recurrent or continuous trouble bring gradual and bitter realization of the physician's ignorance and the patient's true condition: these patients with acute perianal abscesses should be informed not that they "may have" or "will have" a fistula, but that they have a fistula and that they will continue to have this fistula until provision is made for its operative eradication either at the time of incision and drainage of the abscess, or at a later date.

Rather than reiterate all that has been said elsewhere in the literature, we choose to emphasize but few salient points from our own experience. Another such item of pathology, pertinent from a clinical standpoint, is the fact that these fistulas are not just artificial passageways, but, being remnants of acute or chronic infection, are surrounded by appreciable scar tissue. That is, exclusive effort is often made at operation to trace the passageway by various means, whereas tracing the tract by its scar tissue is usually easier and more effective. This is accomplished by palpation, if performed correctly. Using the forefinger alone in the anal canal, one gains little more than a sense of warmth; if, however, the thumb be opposed to it, on the outside, the scar tissue can usually be easily felt and traced. Using this maneuver will often locate sub-

mucous and other extensions, missing of which is a common source of recurrence. When all the scar tissue is removed and the structures feel uniformly soft between the forefinger and thumb, as they are swept around, the fistula is eradicated. By this means, also, one is kept continuously informed of the location of structures important to preserve, and the relation of the tract to them.

Understanding of the surgical anatomy involved is even more essential than a knowledge of pathogenesis and effects of ignorance even more disastrous. Cases of postoperative total incontinence are common, unforgivable, and tragic. We have operated on four such during the past year, and these remedial plastic operations are difficult of successful outcome. More common are the cases of relative incontinence involving limited control, particularly regarding seepage of fluid or passage of gas. Proctologists see quite a few of these cases and encounter not a little hesitation toward rectal surgery because of occurrences among friends of prospective patients. While it is true that many of these cases of relative and total incontinence are due to the vicious practice of postoperative packing, from our observations most of them have been due to injudicious surgery from ignorance of the surgical anatomy of the region. While even more important, from the standpoint of actual numbers of patients involved, the same factor is responsible for a large per cent of unnecessary recurrences.

In reviewing one hundred consecutive fistula operations, we found that 10 per cent of them had been previously unsuccessfully operated elsewhere. Translated into avoidable days of disability, of added suffering and expense, this figure is unpleasant to contemplate. Born of righteous fear of injury to the sphincter mechanism and of unfamiliarity with the applied surgical anatomy in relation to fistulectomy, too often the choice is made between unguided radical surgery with resultant degrees of incontinence, on one hand, or timid surgery with high recurrence rate, on the other. In ignorance of what and where and how it is safe to cut, one avoids incontinence only to stumble far too frequently into the pitfall of avoidable recurrences.

Much of the fault for this state of affairs must be laid at the door of the proctologist, for while each proctologist has learned by exceptional experience the practical surgical anatomy adequate for his own use, his written formulations on which others must depend for guidance have proved, in many respects, inadequate and confusing.

For example, one can read that the relationship of fistulas to the muscles comprising the sphincter mechanism is such that it is usually necessary in eradicating the fistula to sever only part of the external sphincter; or similarly elsewhere that the whole muscle is usually involved; that fistulae may or do not course deep to the internal sphincter. If one believes that continence is chiefly dependent upon the external sphincter, he can find support for his view in the literature, as can one who has the far different impression that it is chiefly dependent upon the internal sphincter, or again upon a composite structure—the anorectal ring. One proctologist states that he has severed the entire sphincter mechanism six hundred times, while another states that fistulae with relationships necessitating such treatment "are, fortunately, rarely seen even in a large experience," and that if the whole sphincter mechanism be entirely severed, even in stages, that function would be definitely impaired. There are differences as to what can safely be done in one stage, and what should be done in two; and frequently no mention at all of this or other disputed points. There are differences of opinion as to the safety of procedure in the posterior quadrant, and as to its relative safety as compared with the lateral and anterior quadrants.

Much of misstatement and confusion has been due to erroneous assumptions of surgical anatomy based on gross inaccuracies of descriptive anatomy handed down from textbook to textbook. For example, most of the above phases of surgical anatomy have been discussed in terms of the external and internal sphincter muscles, the two taken for granted as readily defined entities—if one may judge both by available illustrations, and common and familiar usage.

On the contrary, from our own numerous autopsy dissections, from paraffin sections of the region cut and studied by us, and from the correlation of these with clinical experience, and with special attention to the point, we are convinced that these structures are so difficult of uniform clinical demonstration as to be almost useless for the purposes mentioned. How many surgeons who read these lines and who do fistula surgery feel they could identify accurately both of these muscles during the course of such operation?

From these and other considerations it is apparent that a more easily acquirable and readily usable conception of the surgical anatomy of the region is essential, and based on accurate descriptive anatomy. The topic is too long for clarification in the space available here, but it will soon be separately presented by us elsewhere in detail.

* * *

II. SYMPTOMS

Gordon F. Helsley (800 Monterey Boulevard, San Francisco).—Gant[1] devotes eighty-six pages to the subject of anorectal fistula and of these only two pages to symptoms. Discussion of symptoms is ordinarily practically limited to the painful swelling of the initial abscess and recurrent closure. Complicated and unusual fistulae, particularly tuberculous, receive more attention than their frequency warrants.

The symptom of pain with defecation is mildly present in most cases of simple fistulae. In incomplete external fistula this pain is usually absent. A fistula with an external opening manifests itself by a purulent discharge, usually slight, often foul-smelling. This drainage is frequently totally interrupted by spontaneous closure, and then the same symptoms appear as in all pararectal abscesses. Before swelling, pain, and fever are far advanced, spontaneous or artificial reopening occurs, with prompt relief.

However, in most cases the drainage is probably chronically imperfect. I have seen, as a result of

[1] Diseases of the Rectum, Anus, and Colon.

extirpation of these fistulae, the same improvement that we expect from the elimination of any focus of infection. Thin patients gain weight. Myalgias, neuralgias, and arthralgias of wide distribution disappear. So the symptomatology of anorectal fistulae includes for me consideration of the general malign results of focal infection.

The presence of a fistula is a psychic insult; its cure is a psychic relief. This effect is inextricably mingled with the general effects of the removal of an infected focus.

Escape of gas and feces through a fistula, the classical symptom of a complete fistula, is not often seen. Woe betide the examiner who concludes, because there is no such escape and because a probe fails to pass through into the rectum, that the fistula has no internal opening. Palpation of the tract and the indurated internal opening is valuable. Visual examination through a sphincteroscope is always to be done. With the instrument passed well in and then slowly withdrawn while a weak solution of gentian violet is injected into the external opening, the internal opening will be demonstrated if there is one, and there almost always is.

* * *

III. TREATMENT

William H. Daniel, M.D. (911 Wilshire Medical Building, Los Angeles).—The successful treatment of anal fistulae consists in the removal of all infected tissues, with preservation of the normal function of the rectal outlet. The length of this paper does not permit the detailed description of the treatment of all types of anorectal fistulae, and this discussion will be limited to the more common forms which are designated "fistulae in ano." With few exceptions, anal fistulae result from the rupture or incision of abscesses which arise from the extension of infection from an anal crypt or fissure. Primarily, the management of a fistula begins with the diagnosis of an abscess. Every abscess should be drained by incision as soon as the presence of pus is determined. It is not good surgical practice to allow an abscess to continue to burrow and extend into important tissues while waiting for it to "point."

Depending upon the nature of the abscess from which the fistula results, the fistulous tract may be superficial to the external sphincter muscle; may penetrate the muscle; may pass entirely above the muscle; may be straight; may be tortuous; and even may extend across the posterior or anterior raphe to the opposite side. It is always necessary to determine, before operation if possible, the relation of the external to the internal opening. Many times the fibrous tract may be outlined by palpation, and the internal opening may be felt in a depression in the anal wall corresponding to a recent or chronic fissure, or ulcer. A fine malleable probe will often follow the tract with little difficulty and with slight discomfort to the patient. If a probe is not easily passed, the injection of a staining fluid, as methylene blue, may establish the presence, and frequently the location, of an internal opening. When the external opening is some distance from the anal margin, and the internal opening is not readily located, an x-ray plate, taken following the injection of bismuth paste, or lipiodol, is valuable. In some cases, neither the probe nor the staining solution will traverse the whole tract, due to an angulation or other occlusive process. If the internal opening has been found, a bent probe may be passed from within outward and the tract determined in this manner. Since the majority of fistulae originate in the posterior quadrant, the internal opening should be found in the posterior midline, or slightly to either side, corresponding to the five, six, and seven stations of the clock dial.

The cure of a fistula depends upon the eradication of the internal opening and all infected tracts and sinuses. In plain words, a tunnel from the skin to the lumen of the bowel must be converted into an open trench. The relations of the external and internal openings, and the intervening tract having been determined, the operative procedure is varied according to the size and location of the fistula, and the amount of involvement of the sphincter muscle. As a rule, an incision is made through the skin to circumscribe the external opening, deepened into the fatty layer beneath, and the tract followed by freeing all tissues from the fibrous tube. As the dissection nears the anal margin, the sphincter muscle must be carefully separated from the fistula wall until it is determined that the tract traverses, or passes above, the muscle at or nearly at a right angle. If only the superficial portion of the muscle is involved, the incision may be carried through it without fear. When the tract passes above the external sphincter, and only a moderate amount of tissue has been sacrificed in the dissection, the muscle is incised as in the more superficial type. In those cases in which the tract and its extensions involve a greater area, and a large wound results from dissection, it is safer to place a linen ligature around the muscle at the primary operation. As the wound heals, the new tissue formed prevents the muscle-ends from retracting and thus being united by a large amount of inelastic scar tissue, which may cause a partial incontinence. The bridge of muscle thus surrounded by the linen is incised under local or other anesthesia when the wound has partially healed. The usual time is within ten days to three weeks. The use of the linen ligature is also valuable when there are two separate and distinct fistulae which involve different parts of the anal structure. One fistula may be completely removed, and the two-stage procedure used for the second one. If there are more than one external opening communicating with one internal opening, it is best to connect all the external openings before incising through the internal opening. The dissection of all the fibrous tissue is carried out as in the removal of a single fistula. In a few cases the tract is superficial to all muscles, and a simple removal of all infected tissue results in a cure. All scar tissue in the anal canal surrounding the internal opening should be removed. To prevent the possibility of incontinence it is important to preserve the large nerve trunks which traverse the loose tissues surrounding the anus and rectum. It is advisable to remove all other pathology, as hemorrhoids, papillae, and crypts, at the primary operation.

In all fistula wounds the skin margins should be excised one-half to one inch from the underlying

tissue, and the edges beveled. This procedure provides ample drainage, makes packing unnecessary, and allows healing to proceed from the bottom, with a resultant small wound covered by normal integument. As a general rule, clean excision of all infected tissue is advisable. The mere incision of the roof of a fistula leaves most of the fibrous tract and results in a depressed scar which is, at times, quite unsatisfactory to the patient.

When the fistula is located in an anterior quadrant, especially in women, greater care must be exercised to prevent loss of muscle function. It is probably safer to use the two-stage procedure, especially when the dissection involves more than a small amount of tissue. In some cases in women, partial incontinence may follow incision of the muscle under any procedure, and the attempt is made to cure the fistula without severing the sphincter muscle. The fistulous tract is dissected out in the usual manner, but is severed at the anal wall. The scar tissue in the anal canal containing the internal opening is dissected from the skin and mucous membrane. The healthy mucosa is then freed sufficiently from above to be united, without tension, to the skin margin. The internal opening is thus obliterated by being covered by mucous membrane.

The after-care is very important. Packing, if used at the operation, is removed by the second or third day, and the wound is not repacked. The patient is allowed to be up, take sitz baths on the second day, and the bowels are allowed to move on the third day. Vaseline dressings are customary until the patient is up and about, and then the wound is kept dry by dusting with zinc stearate, thymol iodid, or B. F. I. powder. The finger is passed over the base of the wound every few days to prevent bridging. Excessive granulations are removed with the sharp scissors, or by the application of silver nitrate solution of 5 or 10 per cent.

Contrary to popular opinion, very few fistulae are tuberculous, and occur in patients with tuberculosis of some other region. Although patients suffering with pulmonary tuberculosis are frequently affected with abscesses and fistulae, only a small percentage of these lesions are proved to be tuberculous. Surgical treatment is indicated as in any other individual, with the exception that, in the terminal cases, drainage only is provided.

Living Costs.—Household operation costs are higher in small southeastern cities than in similar cities in other parts of the United States, on the basis of a study just completed by the United States Bureau of Home Economics of the United States Department of Agriculture. The data cover a twelve-month period in 1935-1936.

In each income bracket from $250 to $5,000, the 1,106 white nonrelief families whose expenditures were analyzed in four southeastern cities—Albany and Griffin, Georgia; Gastonia, North Carolina; and Sumter, South Carolina—averaged spending more for household operation than did, for example, 1,488 families in four northwestern cities similarly studied—Astoria, Eugene, and Klamath Falls, Oregon, and Olympia, Washington.

Here is how the household operation costs went up in the Georgia and Carolina cities as income rose from $250-$499 to $4,000–$4,999: $67, $101, $131, $168, $190, $224, $260, $285, $326, $378, $471, $505, $584. For similar income groups, the household operation expenses in the Washington and Oregon cities ran: $61, $94, $100, $107, $122, $148, $159, $177, $198, $214, $270, $356, $432.

Included in "household operation" were fuel, light, and refrigeration; paid household help; laundry supplies and laundry sent out; telephone; postage, stationery and pencils; express, drayage, and moving of household goods; water rent; and such incidental items as paper napkins and towels, cut flowers, lawn seeds and plants.

In all but one of the income brackets ($2,250 to $2,499), the northwestern families averaged spending more on automobiles than the southeastern.

The automobile outlay in the southeastern cities ranged from an average of $10 per family per year in the lowest income bracket to $342 in the highest; in the northwestern cities from anaverage of $40 per family per year in one of the lower brackets to $505 in the $4,000 to $4,999 bracket.

Food, biggest item facing the man or woman who has to make the family living, showed an average expense ranging from $218 per family per year at the lowest income level to $828 at the highest in the southeast cities. Clothes, found to be a consistently sizeable item in all the studies of southeastern families—city, village, and farm—ranged from an average of $34 per family per year at the lowest income level to $437 at the highest. The southeastern families had higher average expenditures for clothes than for cars; the northwestern, higher expenditures for cars than for clothes.

For housing, which included all expense during the year on all homes occupied by the family (vacation homes as well as the year-round dwelling) and lodging of family members while away from home, the Georgia and Carolina families spent an average of $70 at the lowest income level and $394 at the highest. On furnishings and equipment—items such as refrigerators, washing machines, pots, pans, mops, washtubs, glass, china, silver, floor coverings, bedding, curtains, furniture, luggage, lamps, and furniture repairs—the outlay ranged from an average of $16 per family per year in the lowest income bracket to $184 at the highest.

Medical care expenditure in these southeastern cities went up as the income level rose, and ranged from an average of $17 per family yearly at the lowest income level to $320 at the highest. For the services of the barber, the beauty shop, and toilet preparations, the families spent an average of $11 per family per year at the lowest income level and $79 at the highest. On recreation, which included paid admissions, fees and supplies for games and sports, radios and musical instruments, toys and pets and dues to social organizations, the families spent from an average of $5 each per year at the lowest income level to $217 at the highest.

The remaining columns of the family expense book, when averaged for the various income classes, showed the following ranges from low to high income levels: Tobacco, from an average of $13 per family to $53; reading, from $1 to $31; education, from $2 to $82; gifts and community welfare, from $7 to $220; travel other than by car, from $2 to $8; other items, from $3 to $51.

At each income level, averages were based on all families, whether or not they spent any money on the item indicated. For instance, a few families that had no medical care whatever during the year were included in computing the medical care averages.

The 138 families whose incomes fell in the class $1,750 to $1,999 (the first income class in which the average income exceeded the average outlay) spent their money as follows: An average of $1,760 spent, of which $513 went to food; $189 to clothing, $220 to housing; $260 to household operation; $85 to furnishings and equipment; $170 to automobile; $5 to other travel and transportation; $41 to personal care; $81 to medical care; $54 to recreation; $38 to tobacco; $17 to reading; $11 to education; $67 to gifts and community welfare; and $9 to other items.

Health! Thou most august of the blessed goddesses, with thee may I spend the remainder of my life, mayest thou benignly dwell with me; for if there be any pleasure to be derived from riches, or if there be any delight bestowed on men, or respite from pains, with thee, blessed health, all these flourish and beam effulgent-like the spring arising from the graces; without thee no one is happy.—Ariphron.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

WILLIAM W. ROBLEE.....President
CHARLES A. DUKES.....President-Elect
LOWELL S. GOIN.....Speaker
KARL L. SCHAUPP.....Council Chairman
GEORGE H. KRESS.....Secretary-Treasurer

OFFICIAL BUSINESS

ASSOCIATION ACTIVITIES

1. *Call for Special Session: House of Delegates of the California Medical Association.*
2. *Members of House of Delegates, Thirty-Fifth Annual Session at Pasadena, and of Special Session at Los Angeles, December 17 and 18, 1938.*
3. *Special Committee on Medical Service Plans: A Progress Report.*
4. *Council Minutes, 268th Meeting, Held on November 12, 1938.*
5. *Executive Committee Minutes, 156th Meeting, Held on November 12, 1938.*
6. *Medical Service Plans.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Itinerary of President Roblee and Party: A Visitation Tour in Northern California.*
2. *Medical-Hospital Care—California Plan.*
3. *Proposed Chiropractic Initiative.*

CALL FOR SPECIAL SESSION*

HOUSE OF DELEGATES OF THE CALIFORNIA MEDICAL ASSOCIATION

San Francisco, November 25, 1938.

Notice of Special Meeting

To the Members of the House of Delegates of the California Medical Association:

The Council of the California Medical Association at a special meeting thereof, duly held on Saturday, the twelfth day of November, 1938, at San Francisco, California, by the affirmative vote of all members present, constituting more than two-thirds of all of the members of the Council, adopted the following resolution calling a special meeting of the House of Delegates:

Resolved, That a special meeting and session of the House of Delegates of this Association, California Medical Association, is hereby called to be held at 1925 Wilshire Boulevard, in the city of Los Angeles, State of California, on Saturday, the seventeenth day of December, 1938, at the hour of 9 o'clock a. m. for the purpose of:

(*a*) Considering and acting upon any plan or plans presented by the Council for prepayment of, or pooling funds for, health services and care, and for the establishment of a state-wide system to render medical service and hospital care.

(*b*) Considering and acting upon a proposal to amend Chapter II of the By-Laws of the Association relating to professional ethics; and

(*c*) Considering and acting upon the formation and organization of a corporation and any other matters ancillary or related to any or all of the foregoing purposes as may be presented by the Council; and be it

Further Resolved, That George H. Kress, the Secretary of this Association, be and he is hereby directed to prepare a written notice setting forth the time and place of meeting and the purposes and objects thereof and transmit the same, signed by him and attested by the President, the Chairman of the Council, and the Speaker of the House of Delegates, to each member of the House of Delegates in the manner and within the time required by the Constitution of the Association.

* * *

Secretary's Notice.—Pursuant to said resolution of the Council, you and each of you will hereby please take notice that a special meeting of the House of Delegates of the California Medical Association will be held at 1925 Wilshire Boulevard, in the city of Los Angeles, State of California, on Saturday, the seventeenth day of December, 1938, commencing at the hour of 9 o'clock a. m. of said day, and that the objects and purposes of said special meeting are those objects and purposes set forth in the resolution of the Council, above quoted.

The delegates and alternates who shall be eligible to be seated in the House at said special session shall be those delegates and alternates who were eligible to serve on the first day of May, 1938. (At the California Medical Association annual session at Pasadena.)

GEORGE H. KRESS,
Secretary of the California Medical Association.

Attest:

WILLIAM W. ROBLEE,
President of the California Medical Association.

LOWELL S. GOIN,
Speaker of the House of Delegates of the California Medical Association.

KARL L. SCHAUPP,
Chairman of the Council of the California Medical Association.

MEMBERS OF HOUSE OF DELEGATES*

Thirty-Fifth Annual Session at Pasadena
May 9–12, 1938

TOTAL DELEGATES (154)
DELEGATES EX OFFICIO (23)

William W. Roblee, Riverside.....President
Charles A. Dukes, Oakland.....President-elect
Howard Morrow, San Francisco.....Past President
Lowell S. Goin, Los Angeles..Speaker of House of Delegates
John H. Graves, San Francisco.....Vice-Speaker of House of Delegates
George H. Kress, Los Angeles....Secretary-Treasurer-Editor
C. L. Emmons, Riverside (1938).....Councilor 1st District
Carl R. Howson, Los Angeles (1939)..Councilor 2nd District
Louis A. Packard, Bakersfield (1940).....Councilor 3rd District
Axcel E. Anderson, Fresno (1938).....Councilor 4th District
Alfred L. Phillips, Santa Cruz (1939)..Councilor 5th District

* See also editorial comment on page 425, and other items on pages 499–503. Also following items in Council Minutes: Item 9 on page 474; Item 12 on page 475; and Item 14 on page 476. News release of November 14 appears on page 478.

* These are the delegates and alternates who were listed in the Supplement of the April, 1938, issue of CALIFORNIA AND WESTERN MEDICINE, on page 8, for service at the Pasadena annual session, May 9–12, 1938, and who "hold over" for the special session of the California Medical Association House of Delegates, at Los Angeles, on December 17 and possibly December 18. **Additional alternates may be elected.**

Karl L. Schaupp, San Francisco (1940).....Councilor 6th District
Oliver D. Hamlin, Oakland (1938).....Councilor 7th District
Frederick N. Scatena, Sacramento (1939).....Councilor 8th District
Henry S. Rogers, Petaluma (1940).....Councilor 9th District
Harry H. Wilson, Los Angeles (1938).....Councilor-at-Large
C. O. Tanner, San Diego (1939).....Councilor-at-Large
William H. Kiger, Los Angeles (1940).....Councilor-at-Large
P. K. Gilman, San Francisco (1938).....Councilor-at-Large
T. Henshaw Kelly, San Francisco (1939).....Councilor-at-Large
Junius B. Harris, Sacramento (1940).....Councilor-at-Large
George G. Reinle, Oakland.....Chairman, Committee on Public Relations

ELECTED DELEGATES

Alameda County (11)

Delegates	*Alternates*
A. A. Alexander	T. F. Bell
Dorothy Allen	W. G. Donald
Leonard Barnard	Fred Ewing
Clarence A. DePuy	Lloyd Kindall
John Dougherty	George Nesche
Edward N. Ewer	Robert S. Peers
Sumner Everingham	T. Eric Reynolds
H. Gordon MacLean	A. C. Seifert
Frank R. Makinson	D. D. Toffelmier
George G. Reinle	H. G. Trimble
H. J. Templeton	H. H. Appeldorn

Butte County (1)

Joseph O. Chiapella	N. T. Enloe

Contra Costa County (1)

Sol N. Weil	L. H. Fraser

Fresno County (3)

G. W. Walker	C. I. Pendergrass
E. J. Schmidt	S. A. Quimby
R. S. Scott	B. Sorauf

Humboldt County (1)

Allan Watson	Curtis Lane Falk

Imperial County (1)

L. C. House	Phillip Hodgkin

Kern County (1)

C. S. Compton	F. J. Gundry

Kings County (1)

P. K. Edmonds	Name not received

Lassen-Plumas-Modoc Counties (1)

Name not received	Name not received

Los Angeles County (45)

L. A. Alesen	F. X. Ammann
E. Vincent Askey	C. Max Anderson
Samuel Ayres, Jr.	V. L. Andrews
Wilbur Bailey	A. A. Blatherwick
Harold Dewey Barnard	Lewis P. Bolander
Karl M. Bonoff	Henry T. S. Bonesteel
T. D. Caruso	H. B. Breitman
H. L. Charles	E. M. Burns
Fred B. Clarke	O. W. Butler
Walter R. Crane	Donald Cass
John W. Crossan	R. Manning Clarke
William H. Daniel	A. B. Cooke
Edward B. Dewey	Cyril B. Courville
George Dock	Charles H. Cowgill
Wallace Dodge	Egerton Crispin
Ralph B. Eusden	R. L. Cunningham
Alvin G. Foord	Wirt B. Dakin
Henry C. Gernand	Kenneth S. Davis
Orrie Ghrist	John B. Doyle
V. J. Keating	Roy E. Fallas
E. Eric Larson	William V. C. Francis
William H. Leake	John D. Gillis
George D. Maner	Leland Hawkins
William R. Molony, Sr.	Charles M. Hayes
E. Earl Moody	Malcolm R. Hill
Thomas Chalmers Myers	A. B. Hromadka
John W. Nevius	Morrill L. Ilsley
John P. Nuttall	Isaac H. Jones
Frank W. Otto	W. E. Macpherson
Charles E. Phillips	Orville Meland
Sterling N. Pierce	Robert J. Moes
F. M. Pottenger, Jr.	George H. Patterson
H. A. Putnam	Paul A. Quaintance
Robert E. Ramsay	Marcus Rabwin
E. T. Remmen	Oscar Reiss
John C. Ruddock	Paul B. Roen
Philip Stephens	H. E. Schiffbauer
F. C. Swearingen	V. DeMott Sedgwick
R. G. Taylor	Kenneth E. Smiley
Roy E. Thomas	Willard Stone
Donald G. Tollefson	Roy A. Terry
George D. Wells	H. D. Van Fleet
Walter Wessels	Harry J. Wiley
Howard F. West	Burnett W. Wright
A. Herman Zeller	Charles S. Young

Marin County (1)

Anne H. Brady	Carl W. Clark

Mendocino-Lake Counties (1)

Delegates	*Alternates*
R. A. Cushman	Thomas P. Hill

Merced County (1)

E. A. Jackson	A. C. Atwood

Monterey County (2)

James H. McPharlin	W. H. Farr
Mast Wolfson	J. A. Merrill

Napa County (1)

George I. Dawson	Dwight H. Murray

Orange County (3)

G. Wendell Olson	Milo K. Tedstrom
Dexter Ball	Harold F. Gobar
Harry Huffman	Merrill Hollingsworth

Placer County (1)

Lucas W. Empey	Mildred E. Thoren

Riverside County (2)

A. L. Bramkamp	H. L. Ratliff
Bon O. Adams	R. B. McCarty

Sacramento County (3)

Frank MacDonald	Wayne Pollock
Raymond Wallerius	Paul Guttman
Harry Kanner	Ralph Teall

San Benito County (1)

R. L. Hull	R. S. Geen

San Bernardino County (3)

A. D. Neubert	T. I. Zirkle
Walter Cherry	R. C. Nichols
X. Olsen	A. L. Weber

San Diego County (6)

Winston C. Crabtree	B. F. Eager
James F. Churchill	Ralph Kaysen
S. J. McClendon	W. L. Garth
F. E. Toomey	J. G. Omelvena
A. J. Cooper	W. W. Belford
Willard H. Newman	C. W. Lane

San Francisco County (17)

H. Glenn Bell	Zera E. Bolin
Elbridge J. Best	Leroy Brooks
Frederic C. Bost	Howard A. Brown
Edwin L. Bruck	John W. Cline
G. Dan Delprat	Leo Henry Garland
J. C. Geiger	Ernst Gehrels
Thomas E. Gibson	Frank Hand
Philip K. Gilman	Nelson J. Howard
Harold A. Hill	Thomas J. Lennon
Irving S. Ingber	Mary Jones Mentzer
Alson R. Kilgore	James W. Morgan
Stanley H. Mentzer	Gunther W. Nagel
Robert R. Newell	Gerald B. O'Connor
George Warren Pierce	Leon O. Parker
Dohrmann K. Pischel	Robert S. Stone
John J. Sampson	David A. Wood
Roland P. Seitz	Rodney A. Yoell

San Joaquin County (3)

D. R. Powell	C. A. Broaddus
G. H. Sanderson	G. H. Rohrbacher
J. F. Doughty	C. V. Thompson

San Luis Obispo County (1)

Charles R. Kennedy	Earl B. King

San Mateo County (2)

Hartzell H. Ray	N. D. Morrison
J. Garwood Bridgman	H. Wade Macomber

Santa Barbara County (3)

H. E. Henderson	Hugh Freidell
Caleb Stone	Dan M. Clark
E. L. Markthaler	P. A. Gray

Santa Clara County (4)

Stanley R. Kneeshaw	Merlin T.-R. Maynard
Cecil M. Burchfiel	George L. Barry
Russel V. Lee	John H. Shephard
C. Kelly Canelo	Earl O. G. Schmitt

Santa Cruz County (1)

M. D. McPherson	R. S. Rood

Shasta County (1)

Name not received	Name not received

Siskiyou County (1)

James B. McQuire	Edward F. Carlson

Solano County (1)

John W. Green	Durward B. Park

Sonoma County (1)

A. A. Thurlow	L. W. Hines

Stanislaus County (1)

R. S. Hiatt	Hans Hartman

Tehama County (1)

O. T. Wood	R. G. Frey

Tulare County (1)

R. C. Hill	Austin V. Miller

Ventura County (1)

G. C. Coffey	A. A. Morrison

Yolo-Colusa-Glenn Counties (1)

John H. Woolsey	Joseph E. Tillotson

Yuba-Sutter Counties (1)

Stanley Parkinson	E. E. Gray

SPECIAL COMMITTEE ON MEDICAL SERVICE PLANS: A PROGRESS REPORT

(CONFIDENTIAL)

CALIFORNIA MEDICAL ASSOCIATION

November 26, 1938.

To (1) Eligible Members of the House of Delegates of the California Medical Association, and

(2) The Presidents and Secretaries of the Component County Societies:

The Council of the California Medical Association on November 12, 1938, directed its Special Committee on Medical Service Plans to draft, with the assistance of the Association's Legal Counsel, a medical service plan in accordance with the tentative plan submitted to the Council at said meeting and prepare it for submission on or prior to the meeting of the House of Delegates on December 17, 1938.

The Special Committee and the Legal Counsel are devoting their time to the preparation of a plan in accordance with the Council's instructions. Meanwhile, it is felt that the members of the House of Delegates should be informed with respect to the nature of the plan in the process of development. Therefore, this interim report is submitted for your information and guidance with the express request that its subject matter remain wholly confidential and under no circumstances be discussed outside of your county medical society.

The Committee is formulating a plan containing the following fundamental principles:

1. Creation of a medical service organization to operate on a *nonprofit* basis.

2. All doctors of medicine in the State to be eligible to render services under the plan without special privilege to or discrimination against any individual or group of individuals.

3. Complete freedom of choice to the beneficiaries of the plan in the selection of a physician and surgeon who is willing to render services under the plan.

4. Prepayment of the cost of medical services and hospital care on a monthly budgeting basis, all funds collected to be used for defraying cost of medical services, hospital care, administrative overhead and the building up of a reasonable reserve for contingencies such as epidemics, etc. Administrative overhead to be maintained at the lowest possible figure consistent with efficient operation and normal growth.

5. Control of administration and policy of the plan to be vested in the medical profession through its representatives (the committee, however, recognizes the interest of the beneficiaries and the public in the *funds* which will be administered and intends to safeguard such funds).

6. Restriction of hospital care to matters included in the statutory definition of hospital services, viz.: "Maintenance and care in hospital, nursing care, drugs, medicines, physiotherapy, transportation, material appliances and their up-keep."

7. Medical services to be paid for out of available pooled funds on the "unit system." The unit system has been determined upon because no other method will insure against insolvency or bankruptcy and because it is evidence to the public of the good faith of the medical profession in the developmental period of this plan.

8. Beneficiary membership in the plan to be open to all California residents falling within the restricted income groups as rapidly as arrangements can be made therefor.

9. The scope of medical service is contemplated to include everything except industrial injuries, accidents or illness arising from lawlessness, insanity, mental disease, alcoholism, and drug addiction. Restrictions necessarily must be placed upon cases of pulmonary tuberculosis, pregnancy, miscarriage, and childbirth.

10. The administration of the plan shall be in charge of a board of trustees selected by representatives of the California Medical Association.

11. A medical director, with necessary assistants, responsible to the Board of Trustees and employed to serve at their pleasure, shall administer the plan and perform the duties usually performed by a medical director where beneficiaries' funds are pooled. The medical director shall be a doctor of medicine, not engaged in private practice.

12. District administration will be developed.

13. The Board of Trustees to have power to establish rules and regulations governing the administration of the plan.

The foregoing constitutes the general principles involved. In addition, it is important to bear in mind that the Committee definitely will not consider any terms or conditions which will in any way restrict the patient's freedom of choice, work to the advantage of one group of physicians at the expense of another, result in lay control, burden the plan with unnecessary administrative overhead, or tend to place the medical profession in a selfish or otherwise disadvantageous light before the general public, to whom the Committee believes the medical profession owes a distinct duty and trust.

In conclusion, may we again state that it is of vital importance that this report be considered wholly confidential. Any unauthorized disclosure of the contents hereof will inevitably prejudice the efforts of the medical profession without any benefit to anyone, including the informant.

Respectfully yours,

SPECIAL COMMITTEE ON MEDICAL SERVICE PLANS.
By Charles A. Dukes, Chairman.

* * *

November 29, 1938.

Regarding Special Session of California Medical Association House of Delegates: Secretary's Letter

To Be Held in Los Angeles on Saturday and Sunday December 17 and 18, 1938

To the Component County Medical Societies of the California Medical Association (Officers, Delegates, Alternates, and Members):

Dear Doctors:

Your attention is called to the following:

I. *Enclosures:*

Enclosed herewith appears the call of the special session of the House of Delegates of the California Medical Association, with roster of members of the California Medical Association who were listed as delegates and alternates on May 9 to 12, 1938, when the annual session was held this year in Pasadena.

II. *Who Are the Delegates to the Special Session on December 17?*

When the roll of the House of Delegates is called, those who will be seated, in the order of prior sequence, will be:

1. California Medical Association members who were officially listed as delegates for this year's annual session at Pasadena, May 9 to 12, 1938.

2. California Medical Association members who at that session were on the official list of alternates (see again the list).

3. California Medical Association members who *since* the special session was authorized at the November 12 meeting of the Council have been elected as alternates to fill probable vacancies existing in County Medical Society delegations.

(Note: Component county societies, in regular or special meeting, or through duly constituted boards or officers are urged to elect or appoint such additional alternates, as may

be indicated, in order that each component county society may be represented by a full delegation.)

III. *Expenses of Members:*

The California Medical Association will pay railroad and Pullman fares of seated members of the House of Delegates. The amount of additional expenses that will be paid by the California Medical Association (hotel and meals) will be decided by the Council at its meeting on the day prior to the House of Delegates session.

(Expense reports will be available at the registration desk for delegates. Every seated delegate should fill in the expense report and mail promptly to the Central Office of the Association: California Medical Association, Four Fifty Sutter, San Francisco.)

IV. *Place of Special Session:*

The House of Delegates will meet in the auditorium of the headquarters of the Los Angeles Medical Association at the northeast corner of Wilshire Boulevard and Westlake Avenue (1925 Wilshire Boulevard). Telephone: Drexel 7175.

V. *Time of First Meeting:*

On Saturday morning, December 17, at 9:30 o'clock in the morning.

VI. *Time of Second Day's Meeting:*

It is not known at this writing whether a second day's session will be held, but present indications point to such. Delegates should, therefore, count on being in Los Angeles both on Saturday the 17th and Sunday the 18th of December.

VII. *Hotel Headquarters:*

The Hotel Biltmore at Fifth and Olive streets, Los Angeles, has been selected as the central hotel headquarters. Members of the Council will be housed there and as many delegates as possible.

VIII. *Registration Card:*

A registration card is enclosed herewith, the lower portion of which should be filled in for use in registration:

1. At the hotel where you will stay; and

2. The remaining or upper portion to be likewise filled in and handed to the clerk at the registration desk in the meeting place. (Attention to this in advance will expedite registration at both places, and aid in better keeping of records.)

IX. *Meals on Meeting Days:*

On Saturday morning, December 17, a luncheon will be provided by the California Medical Association in the dining room of the Los Angeles Medical Association (on the second floor, with overflow in the rear of the auditorium). On Sunday, a buffet luncheon. No evening meals at the Association headquarters.

X. *Miscellaneous:*

Prompt registration will aid greatly in the transaction of business.

The Speaker will call the House to order at the hours agreed upon.

The office personnel of the Los Angeles County Medical Association, located in the rooms to the left as the building is entered, will be glad to be of aid. Feel free to consult them. The facilities of the library of the Los Angeles County Medical Association, in the north wing of the building are also extended. Visit it.

Expense allowances will not apply to residents of Los Angeles.

Special notices will be posted on the bulletin board in the entrance hallway.

If in doubt regarding the foregoing, kindly write or wire the Association Secretary at the Central Office in San Francisco.

The Council requests careful perusal of the above and the enclosures.

(Signed): GEORGE H. KRESS, *Secretary.*

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred and Sixty-Eighth Meeting

Meeting held in Room 209 of the Sir Francis Drake Hotel, San Francisco, Saturday, November 12, 1938, at 9:15 a. m.

1. **Call to Order.**—The meeting was called to order by Acting Chairman Roblee, with the following members present: President William W. Roblee, President-Elect Charles A. Dukes, Past-President Howard Morrow, Speaker Lowell S. Goin, Chairman of the Council Karl L. Schaupp (arriving at 10); Councilors Calvert L. Emmons, Carl R. Howson, Louis A. Packard, Axcel A. Anderson, Oliver D. Hamlin, Philip K. Gilman, Fred N. Scatena, Henry S. Rogers, Junius B. Harris, W. H. Kiger, Harry H. Wilson, T. Henshaw Kelly, Chairman of Public Relations Committee George G. Reinle, Secretary-Editor George H. Kress, and General Counsel Mr. Hartley F. Peart, and his associate Mr. Howard Hassard.

By invitation: Drs. Walter B. Coffey, Morton R. Gibbons, and John H. Graves.

Absent: Dr. C. O. Tanner (absent from California), J. B. Harris, and A. L. Phillips.

2. **Financial Statements.**—Financial statements for the months of September, 1938, and October, 1938, were presented and on motion of Charles A. Dukes, seconded by A. E. Anderson, were approved.

3. **Loan.**—The Association Treasurer reported that, owing to the heavy outlay of funds made necessary to carry on the educational campaign against the State Humane Pound Act (proposed initiative law No. 2), it was found necessary to reëstablish the maintenance fund, in order to meet bills until next year's dues were received.

The Treasurer stated that in compliance with authorization given by the Trustees Of The California Medical Association, given at its meeting, held on October 20, 1938, a loan in the amount of $15,000 to the California Medical Association was obtained from the Crocker First National Bank by the Council's Committee of the Trustees and Council (Council Chairman Schaupp, Executive Committee Chairman Kelly, and Association Treasurer Kress), in accordance with action taken at its meeting on October 1, 1938. Doctor Kress reported that two $10,000 United States Government Bonds had, on proper authorization and action, been transferred from funds of the Trustees of the California Medical Association to be used as collateral for the loan, on the note given by the Committee for The California Medical Association. It was thought the note could be taken up in January next, when the 1939 dues would be payable.

4. **Annuity Insurance.**—The Association Secretary reported that a committee report of May 5, 1937, authorizing annuity payments for several clerical employees had never been recorded in the minutes as having been officially approved.

It was moved by George Reinle, seconded by A. E. Anderson, that the recommendations made in the Report of the Committee on Annuity Insurance, as presented at the Council Meeting of May 5, 1937, be approved. Carried.

5. **Recess of Council.**—At this point the Council recessed, to permit the Executive Committee to meet and consider the 1939 annual budget, as prepared by the Auditing Committee.

6. **Annual Budget.**—After the recess, the Council was called to order by Chairman Schaupp, Chairman of the Auditing Committee Kelly presenting the budget for the next year, as based on estimated income and expense for the year 1939. Chairman Kelly stated that the Auditing

Committee had recommended an allocation of 25 cents per member to two of the medical libraries in California: Lane Medical Library at San Francisco and Barlow (Los Angeles County Medical Association) Library at Los Angeles. It was explained that in return for this financial aid from the California Medical Association, these libraries would send literature to California Medical Association members through their home libraries, or directly to a member, provided the member gave a deposit of amount sufficient to insure return of the literature.

It was moved by George Reinle, seconded by Charles Dukes, that the budget of Association income and expense for the year 1939, as prepared by the Auditing Committee, and approved by the Executive Committee, be approved by the Council for presentation to the House of Delegates. Carried.

Doctor Kelly stated that no allocation had been included in the budget for stenographic assistance for the legal department and asked for discussion of the matter. No addition was made to cover such item in the budget.

7. **Mileage Allowance.** — Attention was called to the considerable expense incident to visitation tours to county societies when made by the President and President-Elect, with Councilors and Association Secretary. To conserve time, especially where frequent railroad service was not obtainable, it was necessary to use automobile service, the auto so used usually carrying two or more passengers on these visitation tours.

It was moved by George Reinle, seconded by Louis Packard, that the allowance for travel expense of the President and President-Elect on official visitation tours, be 10 cents per mile when automobile service was used. Carried.

8. **Fee Schedule.**—Morton R. Gibbons, Chairman of the Special Committee on Fee Schedule, presented a fee schedule he had drafted, as based on the California Industrial Accident Fee Schedule that had been devised and approved by the California Medical Association for industrial accident work in the year 1919. Doctor Gibbons pointed out the difficulty of making an all inclusive fee schedule for medical work, since fee schedules are intended to cover average cases and type of practice; whereas, in the practice of medicine, physicians are continually dealing with unforeseen difficulties which are not contemplated in the fees for average or typical cases, it being desirable that these latter should be passed upon individually. Doctor Gibbons stated that the Industrial Accident Fee Schedule had been based on an income of not to exceed $100 per month, and that for larger salaries an adjustment should be made.

It was moved by William Roblee, seconded by C. A. Dukes, that the fee schedule problem be referred to the Executive Committee for further consideration and action. Carried.

9. **Medical Service Plans.** — President Roblee stated that the Government, commercial agencies and the general public were pressing the medical profession for medical service plans and that in his tour of the State this had been a constantly arising question. For that reason he had suggested that a special meeting of the Council be called to consider the problem and make recommendations to the House of Delegates if deemed desirable.

Motion: It was moved by T. Henshaw Kelly, seconded by A. E. Anderson, that miscellaneous matters on the docket be considered prior to discussion of the topic of medical service.

A vote was taken on the motion, and the motion was defeated.

Doctors Dukes and Reinle spoke of the need for a medical service plan and stated that although no definite plan had been worked out they believed that a plan as they had informally presented it, in conjunction with the three nonprofit hospitalization groups already operating in California (Insurance Association of Approved Hospitals in the Bay Region, the Intercoast Hospitalization Insurance Association in the Sacramento Valley and the Associated Hospital Service of Southern California in Los Angeles and other southern counties), was worthy of careful consideration by the Council. Doctor Dukes stated that the hospitalization service executives of the above named nonprofit organizations had recently held a meeting, at which the addition of medical service to their plans, in coöperation with the medical profession, had been discussed.

Doctor Reinle outlined in chart graphs the set-up of a medical service plan carried on in conjunction with the established hospitalization organizations.

Doctor Walter B. Coffey, Medical Director of the Municipal Health Service System of San Francisco, who had been invited by President Roblee to attend the meeting and discuss medical service, outlined the plan under operation through which medical and hospital service was given to the employees of the City and County of San Francisco, monthly deductions being made from the salary payrolls, as outlined in the October issue of CALIFORNIA AND WESTERN MEDICINE. Doctor Coffey submitted statistical data on the income and costs of the plan in furnishing medical and hospital service, outlined legislative and organizational features, and explained the difficulties to be guarded against in the consideration of any medical service plan. He stated that on the unit basis of payment provided in the San Francisco Municipal plan, hospitalization and professional costs had been paid at the end of the first month, up to 100 per cent of the fee schedule that had been adopted, said fee schedule being about the average of private practice fees, and more than industrial accident rates.

John H. Graves, ex-president of the California Medical Association, and former Medical Director of the California State Compensation Fund, who had also been invited by President Roblee to be present, then gave further details regarding the plan covering the employees of the City of San Francisco; stating that he considered the principles of the plan could very easily be adusted to cover similar service to the people of California on a voluntary basis, and through the members of the California Medical Association.

Doctor Coffey stated that he felt the plan he had proposed and was working under, could be operated as a voluntary as well as a compulsory plan, and read a plan suggested by him for voluntary medical service, as outlined in an address he had recently given.

Specific figures covering cost of operation of the Health Service Plan of the Employees of the City of San Francisco on a unit basis for both hospital and medical care were submitted by Doctor Coffey, he offering to coöperate fully with the Association in any plan the Association might inaugurate.

Dr. Lowell S. Goin, member of the Special Committee on Medical Service Plans discussed the studies of the Special Committee, stating that all members were agreed that some type of service should be offered. Doctor Goin stated that he did not agree with those who felt that the medical service should be offered through the existing hospitalization organizations or through lay representation; he believing that the medical profession had the necessary intelligence to formulate a periodic payment plan of medical service and that the care of the sick was primarily the problem of physicians, as it always had been up to the present time. Doctor Goin called attention to statistics that showed that 93 per cent of the expense of the care of the sick was medical care by physicians, and 7 per cent was hospital care. Doctor Goin then submitted a rough outline of a medical service plan for the information of the Council, stating that although the Committee had not had benefit of legal advice, the plan contemplated the organization of a nonprofit corporation, trusteeship or copartnership or organization with two classes of members, namely, beneficiary members, and professional members giving service; that it would cover all applicants in the aforesaid income groups without social service investigation (which, he stated, if it were used,

would be an objectionable feature to many applicants). Doctor Goin stated the tentative income figure considered was $3,000 per year; that payment of physicians would be on a unit basis; that hospitalization at first would be limited to three weeks, with the possibility of extending the period later; that in the organization of the plan, which would be controlled by physicians, provision would be made for contracts with existing hospitalization organizations, provided they desired the business. Doctor Goin urged at this time that the Council do not endorse any plan, except one formulated and controlled by the California Medical Association.

Doctor Kelly, member of the Special Committee on Medical Service Plans, stated that he was in entire accord with the views expressed by Doctor Goin.

Legal Counsel Peart was then asked for his opinion on types of organization that might be considered in the formation of a medical service plan by the California Medical Association. Mr. Peart stated that the legal aspects of any plan would require study but that he believed that a nonprofit coöperative insurance corporation could be formed under existing California laws, but that this would require a capital of $25,000 (Chapter 9 of Division 2 of Part 2 of California Insurance Code), being the same law under which two of the hospitalization services are now established. Mr. Peart stated that he would have to give further consideration to the legality of a nonprofit corporation with two classes of membership, as such a set-up had been stated to be insurance by the attorney general, although other decisions were to the contrary. Mr. Peart stated that there were objections to a partnership or a joint partnership, especially those of liability and cumbersome operation; and that a stock corporation would be clearly illegal. Mr. Peart stated that amendment of Assembly Bill 1132 (nonprofit hospitalization law: Chapter 11A, Division 2, Part 2 of the California Insurance Code), enacted by the California Legislature in 1937, might be desirable.

10. **Noon Recess.**—At this point a recess was declared for luncheon.

11. **Reconvening of the Council.**—The Council was called to order by Chairman Schaupp, with the following members present: President William W. Roblee, President-Elect Charles A. Dukes, Past-President Howard Morrow, Speaker Lowell S. Goin, Chairman of the Council Karl L. Schaupp; Councilors Calvert L. Emmons, Carl R. Howson, Louis A. Packard, Axcel A. Anderson, Oliver D. Hamlin, Philip K. Gilman, Fred N. Scatena, Henry S. Rogers, Junius B. Harris, W. H. Kiger, Harry H. Wilson, T. Henshaw Kelly, George G. Reinle; Secretary-Editor George H. Kress; and General Counsel Mr. Hartley F. Peart, and his associate, Mr. Howard Hassard.

By invitation: Drs. Morton R. Gibbons, Walter B. Coffey, and John H. Graves.

Absent: Dr. C. O. Tanner (out of State), and A. L. Phillips.

12. **Medical Service Plans.**—Doctor Goin presented the outline of a medical service plan which had been tentatively drafted during the last several months by a special committee of the Los Angeles County Medical Association.

Mr. Peart then explained further the use of the term "indemnity" stating that it was strictly a legal term found in the insurance code and that it meant reimbursement against loss or protection against liability; further, that it would not be necessary to use any of the instruments of insurance terms whatsoever and that any name could be selected for the organization. It was pointed out that any contemplated health service plan should be organized in full harmony with existing laws, and should provide for the free choice of physician.

Doctor Schaupp mentioned the operation of the California Agricultural Workers Medical Service Plan, as sponsored by the Federal and State governments, in relation to free choice of physicians who were eligible to membership in their respective county societies, and stated that there had been no difficulty in obtaining efficient service on that basis.

Doctor Packard reviewed medical conditions in Kern County and pointed out that any voluntary service plan would not reach that large portion of the population who fall below the income group previously mentioned, and suggested that it might be well to have experiments tried in different sections of the State, with a possibility of securing governmental aid.

Doctor Wilson stated that he believed the Association should proceed with the formulation of a medical service plan even though in the beginning, it was found to be inadequate in covering the very lowest income groups, now cared for by the State; and that adjustments could be made later, if necessary. Also, that it would be more desirable for the profession to continue to carry the load of the indigent, if necessary, rather than to sacrifice the time-honored privilege of being the custodians of the health of the people. Doctor Wilson stated that if the plan agreed upon would provide adequate care for the thousands of citizens in the low bracket income groups, then those persons not possessing such means could receive care, as at present, in the existing private hospitals and in county hospitals.

Doctor Wilson then outlined an organization set-up for a medically controlled medical service plan, covering hospitalization service through a contractual agreement.

Doctor Kelly stated that the San Francisco County Medical Society was also ready to go ahead with a medical service plan.

Motion: It was moved by Harry Wilson, seconded by A. E. Anderson, that the Council of the California Medical Association approve in principle, the plan presented by the Special Committee on Medical Service Plans, and that the Committee be and hereby is directed to redraft, with the assistance of the Legal Counsel of the Association, the said plan as submitted to the Council. Carried.

Doctor Schaupp stated that he felt the state dental associations should be consulted in the formulation of any medical service plan, and their ideas and suggestions secured; and that if desirable contractual agreements could be secured, and that the services of the three nonprofit hospitalization organizations should also be used.

Motion: Upon motion of W. W. Roblee, seconded by George Reinle, and unanimously carried by the affirmative vote of all members present, constituting more than two-thirds of all the members of the Council, it was

Resolved, That a special meeting and session of the House of Delegates of this Association, California Medical Association, is hereby called to be held at 1925 Wilshire Boulevard, in the City of Los Angeles, State of California, on Saturday, the seventeenth day of December, 1938, at the hour of 9:00 o'clock a. m. for the purpose of:

(*a*) Considering the acting upon any plan or plans presented by the Council for prepayment of, or pooling funds for, health services and care, and for the establishment of a state-wide system to render medical service and hospital care;

(*b*) Considering and acting upon a proposal to amend Chapter II of the By-Laws of the Association relating to professional ethics; and

(*c*) Considering and acting upon the formation and organization of a corporation and any other matters ancillary or related to any or all of the foregoing purposes as may be presented by the Council; and be it further

Resolved, That George H. Kress, the Secretary of this Association, be and he is hereby directed to prepare a written notice, as provided in Section 3 (i) of Chapter VI of the By-Laws, setting forth the time and place of meeting and purposes and objects thereof and transmit the same, signed by him and attested by the President, the Chairman of the Council and the Speaker of the House of Delegates, to each member of the House of Delegates in the manner and within the time required by the Constitution of the Association.

Motion: It was moved by T. Henshaw Kelly, seconded by J. B. Harris, that the Council authorize the Special Committee on Medical Service Plans to formulate a statement to be released as of even date of this meeting for publicity through the President of the Association. Carried.

13. **United States Public Health Cancer Survey.**—Doctor Dukes stated that the United States Public Health Service, in its survey of cancer, wishes to secure the names of patients with cancer. It was the sense of the Council that this was a violation of the principles of ethics, and that any statistics furnished should be identified by initial only, as in the system provided in the laws governing the reporting of venereal diseases in California.

14. **Ethics.**—Discussion was had of a change in the By-Laws, in relation to the Principles of Ethics. President Roblee suggested that the change apply to Section 4 of Chapter III of the Principles of Ethics of the American Medical Association, to permit impersonal solicitation of patients in nonprofit medical service plans under proper sponsorship.

Motion: It was moved by William Roblee, seconded by Axcel Anderson, and carried, that the proposed amendments to the By-Laws of the California Medical Association, be included in the call for the special session of the House of Delegates, to permit consideration of the same at the special session. The amendments proposed by President Roblee follow:

Resolved, That Section 4 of Chapter III, Principles of Medical Ethics, beginning with the words, "Section 4—Solicitation of patients" and ending with the words, "for the purpose of obtaining patients." be deleted from the Principles of Ethics of the American Medical Association as previously adopted by the House of Delegates of the California Medical Association, and in lieu thereof there be substituted for the California Medical Association, the following:

Section 4. Solicitation of patients by physicians as individuals, or collectively in groups, by whatsoever name these be called, or by institutions or organizations, whether by circular or advertisements or by personal communications, is unprofessional; provided, however, that solicitation of patients by a constituent state association or its component county medical societies (the plan of a component county society having first received the approval of its respective state medical association), acting singly or in groups, when said solicitation of patients is of an impersonal character and is done in the name of the aforesaid constituent units of organized medicine, and for the promotion of medical service plans controlled or approved by such constituent units, and designed to give more adequate medical and hospitalization care and service to citizens of certain stipulated income classes, shall be permissible and shall not be construed as unprofessional. This does not prohibit ethical institutions or constituted state or county medical society units from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional for physicians as individuals, or collectively, or in groups when not acting officially for state or county medical societies, singly or in groups, as before indicated, to procure patients by indirection through solicitors or agents of any kind or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not per se improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

15. **Policies of the Association.**—George Reinle, Chairman of the Committee on Statement of Policies of the Association, reported that statements would be formulated by the Committee from time to time, on legislative questions, in accordance with the instructions of the Committee on Public Policy and Legislation.

16. **X-Ray Service.**—Doctor Reinle, for the Special Committee appointed at the Council meeting of October 1, reported that the contemplated plans in relation to medical service would probably solve the problems incident to the furnishing of x-ray service in medical and hospital service plans.

17. **Farm Bureau Conference.**—Doctor Rogers stated that a meeting of representatives of the Farm Bureau organizations and the Association would be held at the Sir Francis Drake Hotel on Saturday, November 19.

18. **Golden Gate Exposition.**—Secretary Kress stated that he had conferred with officials of the Golden Gate International Exposition and had secured their coöperation in a plan to secure a grant for space for the Cancer Exhibit which the Association contemplated placing at the Golden Gate Exposition.

Doctor Morrow, President of the California State Board of Health, spoke of the proposed exhibits of the State Board of Health for the Exposition.

19. **State Humane Pound Act.**—P. K. Gilman, Chairman of the Committee of the California Society for the Promotion of Medical Research and of the California Medical Association Committee on State Humane Pound Act and Animal Experimentation, reported on the campaign to defeat the State Humane Pound Act (Initiative No. 2).

Doctor Gilman stated that he believed the present pound laws should be revised, and that amendments might be proposed to the next legislature.

Motion: It was moved by W. W. Roblee, seconded by George Reinle, that the present California Medical Association Committees on Medical Research and Animal Experimentation be continued, with power to act, in conjunction with the Committee on Public Policy and Legislation.

Doctor Gilman stated that the California Society for the Promotion of Medical Research would send in a complete report on the State Humane Pound Act, for the Association files.

Motion: It was moved by P. K. Gilman, seconded by George Reinle, that letters of appreciation be sent by the Association Secretary to the secretaries of the county societies, to the Woman's Auxiliaries, to Dr. John W. Crossan and others who had given special aid to bring about the defeat of the State Humane Pound Act. Carried.

Association Secretary Kress reported that in addition to the California Medical Association grant of $7,000 to the California Society for the Promotion of Medical Research, the California Medical Association had itself expended slightly more than $7,000 for postcards and for the maintenance of the suboffice in Los Angeles under the direction of Dr. John Crossan. Also that one report on expenditures was sent to the Secretary of State.

General Counsel Peart stated that the third or final report to the Secretary of State of California on expenditures of the Association in connection with the State Humane Pound Act would be filed within thirty days following election, as soon as the Association Secretary secured all outstanding bills.

20. **Taxes.**—(*a*) California Sales Tax:

The legal department reported that the printers of the OFFICIAL JOURNAL, The James H. Barry Company, had

been assessed by the State of California for a sales tax covering the OFFICIAL JOURNAL and payment should be made by November 15, 1938, otherwise a penalty would be assessed.

The Secretary presented two sales tax bills from The James H. Barry Company, publishers, one for $1,647.22 to cover the quarter periods September 31, 1935 to June 30, 1937, inclusive (overdue), and the other for the last quarter, July to September, 1938, for the sum of $179.28.

It was moved by Charles Dukes, seconded by A. E. Anderson, that the Barry Company be reimbursed for the amounts of State sales tax on CALIFORNIA AND WESTERN MEDICINE, as per bills submitted. Carried.

The Association Secretary called attention to the fact that the State Government had not computed as yet, the sales tax for the quarters covered by the period July 1, 1937 to June 30, 1938, inclusive.

(*b*) Federal Social Security Act (Old Age Unemployment):

Mr. Hassard of Legal Counsel Peart's office, reported that the Association also had been held taxable under Titles 8 and 9 (Old Age Federal Unemployment) and assessment covering the period July 1 to September 30, 1938, in the amount of $57.88 had been paid by the Association.

Mr. Hassard stated that the amount of this assessment of this tax prior to the last quarter had, as yet, not been determined by the United States Commissioner of Internal Revenue, and that it is the intention of the Legal Department of the Association to contest any assessment prior to July 1, 1938, this position being in harmony with that taken by the American Medical Association on the same tax.

(*c*) California Unemployment Tax:

Mr. Hassard stated that he had written to the California Unemployment Reserves Commission but that up to the present time no reply had been received as to the amounts due on that particular tax.

21. **Health and Development Certificates.**—General Counsel Peart reported on the case of the *State Board of Education* vs. *Jordt*, stating that the decision rendered by the Superior Court at Sacramento, held that osteopathic physicians and surgeons were eligible for health and development certificates, and that the case would probably go to the District Court of Appeal.

22. **Empire Medical Service Association.** — General Counsel Peart informed the Council of the provisions of the policy of the Empire Medical Service Association, a medical service association, under lay control. It was felt that the information should be sent to the Secretary of the County Society interested.

23. **Malpractice Policies.** — The General Counsel reported on letters from a member regarding criticism of one insurance company by another.

24. **Pacific Employers' Insurance Corporation.**—General Counsel Peart suggested that in the case of Pacific Employers, which is now being tried in the Supreme Court, the legal counsel be authorized to coöperate with the counsel for the State Accident Commission and the insurance companies. No objection was made to the suggestion.

25. **Jean Ferrell, Inc. vs. United States Pharmacopeal Convention, American Medical Association, California Medical Association, Homer S. Cummings, Attorney-General of the United States, et al.**—Mr. Peart stated that he had received notice of an action in the above case, having to do with the United States Pure Food and Drug Act, and that he was at present trying to secure additional information thereon.

26. **Reprint Costs.**—Secretary Kress reported that the reprint schedule had been revised on the basis of printer's costs, plus 10 per cent.

It was moved by T. Henshaw Kelly, seconded by A. E. Anderson, that the revised schedule of reprint prices be approved. Carried.

27. **Industrial Work.**—A letter from Harry Field regarding the responsibility of treatment of lues in industrial work was presented.

It was moved by T. Henshaw Kelly, seconded by P. K. Gilman that Mr. Field be advised that public health facilities were available for treatment of such patients and that the correspondence be referred to the Department of Public Health. Carried.

28. **Prenatal and Premarital Legislation.**—Secretary Kress reported on the proposed legislation covering prenatal and premarital examinations, as explained to him in a conference with Mrs. E. W. Hafford, representative of the Southern California organization.

Drafts of proposed laws were submitted. These were referred to the Committee on Public Relations, and to the Committee on Public Policy and Legislation.

29. **Golden Gate International Exposition Numbers.** The Secretary presented written requests from the San Francisco *Examiner* and the San Francisco *Chronicle* regarding special editions of the newspapers to be published the day preceding the opening of the Fair.

It was moved by T. Henshaw Kelly, seconded by Louis Packard, that it was against the policy of the Association to authorize the use of its name in such matters. Carried.

30. **Clinics.**—A letter from Louis Packard regarding standards for clinics was presented.

The Secretary stated that all California clinics or groups using the name of clinic were governed by the State Clinic Law, which provided that all clinics were required to secure the official approval of the State Board of Health before operating as such.

31. **Reporting Service.**—Secretary Kress presented the bid of the Yates Reporting Service for report of the meetings of the House of Delegates and General Sessions at the next annual session.

It was moved by William Roblee, seconded by P. K. Gilman, that the Yates Reporting Service be employed on the basis of the bid submitted, dated November 9, 1938. Carried.

32. **Cancer Appropriations.**—It was moved by William Roblee, seconded by A. E. Anderson, that the suggestion to secure some of the Federal Appropriation for Cancer Research be referred to the Cancer Commission. Carried.

33. **Wylie Bed.**—It was the sense of the Council that the Chairman of the Executive Committee and the Secretary formulate a letter of reply to Dr. Arthur E. Varden, Secretary of the San Bernardino County Medical Society, concerning a pediatric bed invented by one of the members, and call attention to the rules laid down for such matters by the American Medical Association.

34. **Nurses' Bill.**—Doctors Harris and Kelly reported on the present status of the proposed law to establish a State Board of Examiners for Nursing.

It was moved by Harry Wilson, seconded by P. K. Gilman, that the Chairman of the Executive Committee in cooperation with the Chairman of the Committee on Public Policy and Legislation write a letter to the county society secretaries, calling their attention to the desirability of not approving proposed laws or other legislative matters without first giving thorough consideration thereto, and securing the viewpoints of the Association, in order not to hamper the work of the Committee on Public Policy and Legislation. Carried.

Ill-advised resolutions of endorsement were most embarrassing when brought forth in Committee meetings, when the legislature was in session, and could seriously affect public health and other interests.

35. **Medical Service Plan at Palo Alto.**—The Association Secretary presented a letter from the Santa Clara County Medical Society regarding methods of procedure in consideration and approval of medical service plans. Doctor Kress stated that copies of the rules and actions taken by the Council and the House of Delegates in relation thereto, had been forwarded to Doctor Magoon, Secretary of the Santa Clara County Medical Society.

It was moved by T. Henshaw Kelly, seconded by J. B. Harris, that the letter of the Santa Clara Society be referred to the Committee on Public Relations. Carried.

36. **Stenographic Text.**—A telegram requesting permission to use excerpts from CALIFORNIA AND WESTERN MEDICINE, for use in a stenographic course of study to be published by the Gregg Company, was read.

It was moved by J. B. Harris, seconded by T. Henshaw Kelly, that there was no objection to use of such copy. Carried.

37. **Medical Practice Act Amendments.** — Doctors Kelly and Harris reported on the proposed amendments to the California Medical Practice Act, regarding interns and residencies, and stated that the Board of Medical Examiners were agreeable to making provision for exception for interns for one year, but objected to any extension of time for a longer period of time.

38. **Institutions Commission.** — Secretary Kress reported that the Board of Supervisors at Los Angeles had adopted on Date of September 27, 1938, a resolution asking for a form of advisory Institutions Commission for the Los Angeles County General Hospital.

39. **Medical and Hospital Care Policies.**—Secretary Kress reported that in accordance with previous Council action, a copy of the General Counsel's opinion on medical and hospital care policies had been sent to all county societies.

40. **Chiropractic Initiative.** — A letter regarding the proposed chiropractic initiative was presented, showing the manner in which that group was proceeding in regard to the proposed initiative law now on file in the office of the California Secretary of State.

41. **Retired Membership.**—The San Francisco County Medical Society having recommended for retired membership Dr. Emma C. LaFontaine of San Francisco, who had retired from practice, it was moved by T. Henshaw Kelly, seconded by A. E. Anderson, that Emma C. LaFontaine be granted retired membership in the California Medical Association. Carried.

42. **Membership Requirement.**—A letter from the San Bernardino County Society relating to residency period was presented and the Secretary was instructed to inform the Society that the Council could not waive the requirement of six months' prior residence, as provided in the By-Laws.

43. **San Francisco Hearing.**—The Secretary reported on the hearing in the case of *Green* vs. *Pischel*, before the San Francisco County Society, as recorded in a copy of a letter containing a resolution of the Board of Directors of the San Francisco Society, dated November 1, 1938.

The Secretary was instructed to write a letter to W. E. Mitchell, M.D., expressing the appreciation of the Council for his services, in acting as a referee in the hearing.

44. **Merced County Hospital.**—A letter from A. E. Anderson regarding pay patients in the Merced County Hospital, for the information of the Council, was read.

45. **Alameda County Workers' Alliance.** — A letter from the Alameda County Workers' Alliance was presented for the information of the Council. Doctor Kress stated that he had referred the Alliance to the State Board of Health as the proper authority in infectious diseases, and had notified the Alameda County Society.

46. **Tuberculosis Committee.**—A letter was read from the American College of Chest Surgeons asking that a Committee on Tuberculosis be appointed.

It was suggested that a State Committee, if appointed, should operate as a subcommittee under the Committee on Medical Education and Hospitals.

It was moved by T. Henshaw Kelly, seconded by Harry H. Wilson, that the Committee on Medical Education and Hospitals be authorized to appoint a Subcommittee on Tuberculosis. Carried.

47. **School Bus Drivers.** — Correspondence from the San Luis Obispo County Society regarding the necessity of physical fitness in school bus drivers was presented. The Council agreed that this matter deserved consideration by those making such appointments.

48. **Adjournment.**—There being no further business, the meeting adjourned.

GEORGE H. KRESS, *Secretary.*

KARL L. SCHAUPP, *Chairman.*

EXECUTIVE COMMITTEE: CALIFORNIA MEDICAL ASSOCIATION

Digest of the Minutes of the One Hundred and Fifty-Sixth Meeting of the Executive Committee

Meeting held in Room 209 of the Sir Francis Drake Hotel, San Francisco, Saturday, November 12, 1938, at 10 a. m.

Chairman Kelly stated that in accordance with Chapter IV, Section 4 of the By-Laws, it was necessary for the Executive Committee to consider the tentative budget for the year 1939, as prepared by the Auditing Committee.

As chairman of that committee, Doctor Kelly then discussed the budget items, explaining why additions and subtractions had been made.

The budget as submitted was approved.

GEORGE H. KRESS, *Secretary.*

T. HENSHAW KELLY, *Chairman.*

MEDICAL SERVICE PLANS

A News Release

A press release of Monday, November 14, appears below:

Dr. W. W. Roblee of Riverside, President of the California Medical Association, with a membership of 6,000 physicians, made an important and interesting announcement today.

"The Council of the Association," said Doctor Roblee, "at its meeting in San Francisco today, directed its Committee on Medical Service to put into final form a plan by which medical and hospital service will be furnished to citizens of California and their dependents on a monthly payment basis.

"The plan will be operated by the California Medical Association or its representatives, and will provide the services of all licensed doctors of medicine in the state who are willing to abide by the rules and regulations necessary to operate the plan.

"The subscribers will have free choice of physicians in this group and also of hospitals, for it is contemplated to use the facilities of the three large hospital service associations which have pioneered hospital service plans in California, Insurance Association of Approved Hospitals in the Bay region, the Intercoast Hospitalization Insurance Association in the Sacramento Valley, and the Associated Hospital Service of Southern California in Los Angeles and other southern counties.

"The Council has called a special meeting of the House of Delegates of the Association to meet in Los Angeles on December 17 to approve the final plans which will speedily be put into operation after their approval."

The life, the fortune and the happiness of every one of us depend upon our knowing something of the rules of a game infinitely more difficult and complicated than chess. It is a game which has been played for untold ages, every man and woman of us being one of the two players in a game of his or her own. The chess board is the world, the pieces are the phenomena of the universe, the rules of the game are what we call the laws of nature. The player on the other side is hidden from us. We know that his play is always fair, just and patient. But we also know, to our cost, that he never overlooks a mistake, or makes the smallest allowance for ignorance. One who plays ill is checkmated without haste, but without remorse.—Huxley.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Itinerary of President Roblee and Party; In Visitation Tour in Northern California

Commencing on Wednesday, November 2, at Napa, and closing on Tuesday, November 15, at Sacramento, President W. W. Roblee of Riverside, with President-Elect Dukes, Councilors Rogers, Scatena, and Phillips, Association Secretary Kress and Past President Peers (two or more of them), were present at meetings held as follows: Yountville, Chico, Marysville, Redding, Yreka, Eureka, Agnew, Del Monte, Auburn, and Sacramento.

The guest speakers gave talks on organization problems and present-day trends in medical practice, and exchanged fraternal greetings with Association members living in the districts visited.

The itinerary is given in table below.

Medical-Hospital Care—California Plan Devised

Los Angeles, November 17—(UP).—America's first extensive medical service plan to provide doctor and hospital care at low costs to a majority of wage earners and their families was outlined today by leaders who will submit it to the California Medical Association next month.

Representing six years of study and research, the plan was explained in detail for the first time to two thousand members of the Los Angeles County Medical Association by Dr. Lowell S. Goin, speaker of the California Medical Association's ruling house of delegates and chairman of the county and state committees in charge of the program.

"PARI-MUTUEL" SYSTEM

The plan, eagerly awaited by the American Medical Association which traditionally has opposed all such theories, provides in effect a "pari-mutuel" system of fees to cooperating physicians and unlimited medical service and limited hospitalization to subscribing families at a maximum cost of $72 a year.

The program, if approved December 17 by the house of delegates, will be binding upon all county medical units in the State. Professional membership is optional, but in the view of leaders the implied penalty of loss of patients to non-coöperating physicians would make membership virtually mandatory.

PROVISIONS OF PLAN

Subject to modification, the plan stacks up as follows:

Eligible to subscribe to the service would be all workers earning under $2,500 a year. Costs would start at $2.65 a month for the individual and increase by $1 for each dependent up to a maximum of $6 for the family, regardless of its size. Dependents would be defined on the same basis that the Government defines them for income tax purposes. Patients are free to select their own doctor and hospital.

Subscribers would be guaranteed medical care and hospitalization for all maladies, excepting insanity and mental diseases, acute alcoholism, narcotic addiction, and tuberculosis of the kind where sanatorium treatment is required.

FOR STATE OR UNITED STATES

Broadly speaking, the profession regards these exceptions as cases for state or federal supervision. The service would allow treatment for venereal diseases, but hospitalization for cancer sufferers and those with similar malignant diseases would be restricted to operative and therapeutic treatment.

In all cases, hospitalization would be limited to three weeks per person per year. The average operative case requires only twelve days. Service privileges would apply at once, except for maternity patients, who must have been subscribers for a year.

Coöperating physicians and surgeons would be paid on a basis of "units," the value of which would be determined quarterly by the board of trustees, the administrative body. —San Francisco *Chronicle*, November 19, 1938.

* * *

Proposed Chiropractic Initiative

In the November official journal, on page 356, mention was made of the fact that the chiropractors had secured

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. George G. Reinle of Oakland is the chairman and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

Northern California Itinerary: Doctors Roblee and Kress (with Doctors Dukes, Rogers, Phillips, Scatena and Peers Present at Some of the Meetings)

Date November	Day	City of Meeting	County Society Host	Councilor
2nd	Wednesday	Yountville, Veterans' Home, 7:00 p. m.	Napa	Dr. Rogers
3rd	Thursday	Chico, Hotel Oaks, 7:00 p. m.	Butte	Dr. Scatena
4th	Friday	Marysville, Hotel Marysville, 6:30 p. m.	Yuba-Sutter	Dr. Scatena
5th	Saturday	Redding, Hotel Redding, 6:30 p. m.	Shasta	Dr. Scatena
6th	Sunday	Yreka, Yreka Inn, 2:30 p. m.	Siskiyou	Dr. Rogers
7th	Monday	Eureka, Eureka Inn, 8:15 p. m.	Humboldt	Dr. Rogers
8th	Tuesday	Election Day. No meeting		
9th	Wednesday	Agnew State Hospital, Evening	Santa Clara San Mateo	Dr. Phillips
10th	Thursday	Hotel Del Monte, 7:30 p. m.	Monterey San Benito Santa Cruz	Dr. Phillips
11th	Friday	Hotel Del Monte. No meeting	(To Check on Arrangements for Annual Session)	
12th	Saturday	Executive Committee Meeting, 9:00 a. m.	San Francisco	
13th	Sunday	No meeting		
14th	Monday	Auburn, Freeman Hotel, 6:30 p. m.	Placer	Dr. Scatena
15th	Tuesday	Sacramento, Auditorium, 8:30 p. m.	Sacramento	Dr. Scatena

sufficient signatures to an initiative petition to place the same on the first special or regular state election to be held in 1939 or 1940.

The interesting copy of a letter, printed below, has recently been received. It is worthy of perusal, as will be evident when its paragraphs are scanned. The communication follows:

(COPY)

NATIONAL AFFILIATED CHIROPRACTORS
OF CALIFORNIA, INC.

Alameda, Contra Costa Unit

Oakland, California,
October 24, 1938.

Dear Doctor:

Now that we are definitely on the ballot we are faced with the larger task of publicizing our amendment so that we will not fail at the polls, probably in March, 1939. No matter how just the cause or how worthwhile our bill may be, unless the public is educated the vote will be overwhelmingly no.

As you know, the medical association and others will spend many thousands of dollars to defeat the amendment and unless we are prepared to spend liberally to support our cause, all that has previously been done will go for naught.

The officers of the National Affiliated Chiropractors of California with the approval of the Chiropractic State Board members have contracted with the Professional Credit and Audit System to handle the solicitation of funds for campaign purposes, on a statewide basis. It is necessary that we raise a fund of at least $75,000 and in order to raise that amount, each and every one of the chiropractors actively engaged in practice and all others who take any interest in the advancement of the profession, must contribute at least $50.

In a short while you will be called on at your office by a member of the above firm, either ——— or ———, and we earnestly request that you grant him an immediate interview as our time for raising this fund is indeed limited. He will explain to you how he can help you pay your quota by collecting your outstanding bad bills for you. [*Sic!*]

Dr. ———————
President of A. C. C. Unit

By Dr. ———————
Secretary

Dr. ———————
Secretary, State Board Chiropractic Examiners

* * *

Chiropractic Initiative: Proposed Law

CALIFORNIA AND WESTERN MEDICINE, in its issue of November, 1938, on page 356, called attention to a proposed initiative measure whereby amendments would be made to the existing Chiropractic Practice Act, enacted by initiative on November 7, 1922, and which became legally operative on December 21, 1922.

A copy of the proposed amendments which will go on the ballot of the next State election to be held, either at the regular State election in 1940, or prior thereto, if a special State election is held in the meantime, has been secured from the Secretary of State and is printed below, for the consideration of all who are interested. Comments or suggestions may be sent to the Association Secretary, Four Fifty Sutter, San Francisco, and will be forwarded to the proper committees.

Attention is also called to other items concerning the chiropractic group, printed in this issue: (1) A letter sent out by their association (see above); and (2) the opinion of Superior Court Judge Van Nostrand, on page 457.

(COPY)

Initiative Measure To Be Submitted Directly to the Electors

The Attorney General has prepared a title and summary of the chief purposes and points of said proposed measure, as follows:

Chiropractors. Initiative. Amends title and certain sections of Chiropractic Act; provides secretary of Chiropractic Board shall devote full time to duties and increases his salary; increases powers of board; increases educational requirements of applicant for license; permits licensees to diagnose and treat diseases, injuries, deformities or other physical or mental conditions of human beings, without using drugs or severing any tissues of human body; specifies grounds of and proceedings for suspension or revocation of license; specifies annual renewal license fee and method of reinstating forfeited license; declares licensees shall report communicable diseases and sign birth and death certificates.

State of California, County (or City and County) of .....ss.

To the Honorable, the Secretary of State of the State of California:

We, the undersigned, registered, qualified electors of the State of California, residents of the county (or city and county) of ———, hereby present to the Secretary of the State this petition and hereby propose a law and act entitled as follows: "An act to amend the title and Sections 3, 4, 5, 7, 10, 12 and 13 of that certain act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the state board of chiporactic examiners and declaring its powers and duties, prescribing penalties for violation hereof, and repealing all acts and parts of acts inconsistent herewith," approved by the electors at the general election on November 7, 1922; providing for the organization of the state board of chiropractic examiners, and providing for its officers, duties, powers and compensation; regulating the practice and licensing of chiropractors; defining the scope of practice of licensees; establishing educational requirements and other qualifications for licensees; fixing license and renewal fees; providing for the issuance, suspension, revocation and reinstatement of licenses; providing for investigation and approval of chiropractic schools and colleges; requiring reports of communicable diseases; and repealing all conflicting provisions of other acts, to read as hereinafter set forth in full, and petition that the same be submitted to the electors of the State of California for their adoption or rejection at the next succeeding general election or as provided by law.

The proposed law and act is as follows:

An act to amend the title and sections 3, 4, 5, 7, 10, 12 and 13 of that certain act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the state board of chiropractic examiners and declaring its powers and duties, prescribing penalties for violation hereof, and repealing all acts and parts of acts inconsistent herewith," approved by the electors at the general election on November 7, 1922; providing for the organization of the state board of chiropractic examiners and providing for its officers, duties, powers and compensation; regulating the practice and licensing of chiropractors; defining the scope of practice of licensees; fixing license and renewal fees; providing for the issuance, suspension, revocation and reinstatement of licenses; providing for investigation and approval of chiropractic schools and colleges; requiring reports of communicable diseases; and repealing all conflicting provisions of other acts.

The people of the State of California do enact as follows:

Section 1. The title of that certain act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the state board of chiropractic examiners and declaring its powers and duties, prescribing penalties for violation hereof, and repealing all acts and parts of acts inconsistent herewith," approved by the electors at the general election on November 7, 1922, is hereby amended to read as follows:

"An act creating the state board of chiropractic examiners, and providing for its organization, members, duties and powers; regulating the practice and licensing of chiropractors and defining the scope of practice thereof; providing for the investigation and approval of chiropractic schools and colleges; establishing educational requirements and other qualifications for licensees; fixing license fees; providing for the issuance, suspension, revocation and reinstatement of licenses; prescribing penalties for violation hereof, and repealing all conflicting provisions of other acts."

Section 2. Section 3 of said act is hereby amended to read as follows:

Sec. 3. The board shall convene within thirty days after the appointment of its members, and shall organize by the election of a president, vice-president and secretary, all to

be chosen from the members of the board. Thereafter elections of officers shall occur annually at the January meeting of the board. A majority of the board shall constitute a quorum.

It shall require the affirmative vote of three members of said board to carry any motion or resolution, to adopt any rule, or to authorize the issuance of any license provided for in this act.

The secretary shall receive a salary to be fixed by the board in an amount not less than three thousand six hundred dollars per annum and not more than four thousand two hundred dollars per annum, together with his actual and necessary traveling expenses incurred in connection with the performance of the duties of his office, and shall give bond to the state in such sum with such sureties as the board may deem proper. He shall devote his full time to the performance of his duties as such secretary. He shall keep a record of the proceedings of the board, which shall at all times during business hours be open to the public for inspection. He shall keep a true and accurate account of all funds received and of all expenditures incurred or authorized by the board, and on the first day of December of each year he shall file with the governor a report of all receipts and disbursements and of the proceedings of the board for the preceding fiscal year.

Section 3. Section 4 of said act is hereby amended to read as follows:

Sec. 4. The board shall have power:

(a) To adopt a seal, which shall be affixed to all licenses issued by the board.

(b) To adopt from time to time such rules and regulations as the board may deem proper and necessary for the enforcement of this act, copies of such rules and regulations to be filed with the secretary of the board for public inspection.

(c) To examine applicants and to issue and revoke licenses to practice chiropractic, as herein provided.

(d) To summon witnesses and to take testimony as to matters pertaining to its duties; and each member shall have power to administer oaths and take affidavits in connection with board matters.

(e) To approve every chiropractic school or college which complies with the provisions of this act and the rules and regulations of the board. Nothing in this act shall prohibit the board from withdrawing its approval of any chiropractic school or college after such approval has been granted.

(f) To promulgate and adopt rules and regulations for the conduct of chiropractic schools and colleges. Each chiropractic school or college in order to obtain the approval of the board shall make application therefor to the board in writing, and shall furnish such information regarding such school or college as may be required by the board. Said schools or colleges shall at all reasonable times permit any member of the board or any representative thereof to enter upon the premises of such school or college and to inspect the facilities and records thereof.

(g) To publish an annual directory, a copy of which shall be delivered to each licentiate without cost. Copies of said directory may be sold to other persons at one dollar per copy.

(h) To employ an assistant secretary, inspectors, attorney, and such other clerical assistance as the board may deem necessary.

(i) To do any and all things necessary or incidental to the exercise of the powers and duties herein granted or imposed.

Section 4. Section 5 of said act is hereby amended to read as follows:

Sec. 5. It shall be unlawful for any person to practice chiropractic in this state without a license so to do. An applicant for a license hereunder must be not less than twenty-one years of age, of good moral character, and must submit satisfactory proof of graduation from a high school requiring not less than fifteen units for graduation. He must apply to said board at least fifteen days prior to any meeting thereof, upon such form and in such manner as the board may provide, and the application must be accompanied by a fee of twenty-five dollars.

Except in cases herein otherwise provided for, an applicant for a license to practice chiropractic must be a graduate of a chiropractic school or college approved by said board, which teaches a course of instruction of not less than four thousand hours in the subjects hereinafter enumerated in this section, extended over a period of four school terms of not less than nine months each.

An applicant for a license hereunder must submit satisfactory proof of actual attendance during not less than 90 per cent of the hours herein prescribed.

For the purposes of this act, an academic "hour" shall be construed as a period of not less than fifty minutes. The hours of instruction and the subjects required of an applicant for a license to practice chiropractic, and the minimum of hours and courses to be taught by an approved chiropractic school or college are as follows:

Subject	*Hours*
Dissection	150
Histology	100
Anatomy	600
Bacteriology	100
Chemistry (including 50 hours laboratory)	150
Hygiene and sanitation	100
Toxicology	50
Physiology	300
Pathology	300
Physical Diagnosis and Analysis	450
Chiropractic Theory and Practice	500
Obstetrics	200
Gynecology	100
Spinography	100
Biology	100
Physics	100
Dietetics, including Endocrinology, Biochemistry, and Food Chemistry	300
Physical Therapy and Practice	300
Total	4000

Section 5. Section 7 of said act is hereby amended to read as follows:

Sec. 7. One form of certificate shall be issued by the board of chiropractic examiners; said certificate shall be designated "License to practice chiropractic," which license shall authorize the holder thereof to diagnose and treat diseases, injuries, deformities or other physical or mental conditions of human beings, without the use of drugs and without in any manner severing any of the tissues of the human body.

Section 6. Section 10 of said act is hereby amended to read as follows:

Sec. 10. (a) Said board shall refuse to grant, or may suspend or revoke a license to practice chiropractic in this state upon any of the following grounds:

First—Procuring or aiding or attempting to procure a criminal abortion.

Second—Violating or attempting to violate, directly or indirectly, or failure to comply with, any provision of this act.

Third—Wilfully betraying a professional secret.

Fourth—Revocation or suspension by a sister state of a license by virtue of which one is licensed to practice in this state.

Fifth—Employing, directly or indirectly, any unlicensed practitioner in the practice of chiropractic, but this provision shall not be construed to prohibit the employment of nurses or other bona fide assistants by licensees under this act.

Sixth—Advertising which is intended or has a tendency to deceive the public or to be harmful to public morals or safety, or the advertising of definite or fixed prices for professional services.

Seventh—Advertising of any treatment, medicine or method whereby the monthly periods of women can be regulated or the menses reëstablished.

Eighth—Conviction of a felony or of any offense involving moral turpitude in which case the record of such conviction shall be conclusive evidence.

Ninth—The purchase or sale, or offer to purchase or sell, the alteration of, or fraudulent use of, any chiropractic or other diploma, degree or license.

Tenth—Fraud in an application or examination for a license.

Eleventh—Practicing chiropractic under a false name or the impersonation of another chiropractor.

Twelfth—Habitual intemperance or excessive use of ardent spirits or narcotics.

Thirteenth—Advertising, directly or indirectly, in any manner, that a licensee hereunder, or any person or company connected with him, will treat or cure, or attempt to treat or cure, any venereal or sexual disease, weakness or disorder.

Fourteenth—Failure or refusal to record a license as required by this act.

Fifteenth—The employment of "cappers" or "steerers" or other persons in procuring chiropractic practice.

Sixteenth—Misrepresentation in connection with alleged rights or privileges to practice as a licensee under this or any other professional act.

(b) Before any license is suspended or revoked by said board, the licensee shall be furnished with a specification of the ground or grounds upon which suspension or revoca-

tion of his license is contemplated and after reasonable notice thereof to the licensee the board shall conduct a hearing in the matter at which time the licensee may be represented by counsel.

(c) If an application for a license is refused by said board, or if after notice and hearing a license issued is suspended or revoked, the aggrieved person may commence an action in the superior court against the board to compel the granting of the application or to cancel the act of the board in suspending or revoking the license, as the case may be, or for any other appropriate relief, such action to be in the nature of a proceeding in review. Every order of the board shall be final and conclusive as to questions of fact. A proceeding to review an order of the board must be filed within thirty days after the issuance of the order and tried in the county in which the board hearing was held or in any county wherein the board maintains an office.

(d) The secretary shall enter in his records the fact of such revocation or suspension, and shall certify that fact to the county clerk of the county in which the license has been recorded pursuant to Section 11 hereof. Said clerk must thereupon endorse that fact, opposite the name of the licensee in his said record. The record of such revocation or suspension so made by said clerk shall be prima facie evidence of the fact thereof, and of the regularity of all proceedings of said board in the matter of said revocation or suspension.

(e) After two years from the revocation of a license said board may make an order of restoration and issue a new license upon application therefor accompanied by a fee of twenty-five dollars.

Section 7. Section 12 of said act is hereby amended to read as follows:

Sec. 12. Each person licensed under this act shall, on or before the first day of January of each year, after a license is issued to him as herein provided, pay to said board of chiropractic examiners a renewal fee of not less than five dollars nor more than ten dollars, to be fixed annually by the board. The secretary of the board shall, on or before November first of each year, mail to all licensed chiropractors in this state, a notice that the renewal fee will be due on or before the first day of January next following. The failure, neglect or refusal of any person holding a license or certificate to practice under this act to pay said annual fee during the time his or her license remains in force shall, after a period of sixty days from the first day of January of each year, ipso facto, work a forfeiture of his or her license or certificate, and it shall not be restored except upon the written application therefor within a period of two years from delinquent date and the payment to said board of a delinquent penalty of ten dollars, together with all renewal fees delinquent, provided that such licentiate who reinstates said license or certificate within the period of two years shall not be required to submit to an examination for the reinstatement of such certificate.

Section 8. Section 13 of said act is hereby amended to read as follows:

Sec. 13. Chiropractic licentiates shall observe all state and municipal regulations relating to the reporting of communicable diseases, and shall sign birth and death certificates and make the required reports and file them with the proper authorities as required by law and such reports shall be accepted by the officers of the departments to which they are made.

COMPONENT COUNTY MEDICAL SOCIETIES

KERN COUNTY

The Kern County Medical Society met in regular session at the Mercy Hospital in Bakersfield on Thursday evening, October 20. Dr. Harry Lange presided.

Dr. Seymour Strongin suggested that a committee be appointed to arrange for the annual meeting and dinner. Doctors Strongin, Lloyd Fox, and Jack Nicholson were appointed.

The Secretary read a report of the committee on the campaign of Dr. Walter S. Franklin for the office of Lieutenant-Governor of California.

Dr. Arthur H. Kegel of Los Angeles presented a paper on the subject, *Thyroid Disease*. He reported on the papers given at the International Thyroid Conference which he attended recently. Recent aspects of endocrinology were stressed.

The meeting was then adjourned. Refreshments followed.

S. M. Loven, *Acting Secretary*.

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PLACER COUNTY

The Placer County Medical Society held its October meeting at the Freeman Hotel in Auburn on October 22. The meeting was called to order by the president, Dr. C. E. Lewis. There were present the following members and visitor: Doctors Lewis, Russell, Peeke, March, Weddle, Karo, Louis E. Jones, Miller, Empey, Lundegaard, Peers, Banks, and Smith. Visitor was Dr. E. A. Casey of Grass Valley.

The application of Dr. Earl A. Casey of Grass Valley for membership was read for the second time. Doctor Casey was unanimously elected.

A third application for membership was read and, after some discussion, it was moved, seconded and carried, that the application be laid on the table.

A letter from Dr. Ellen S. Stadtmuller, Chief of the Bureau of Child Hygiene, State Department of Public Health, was read in which a meeting on pediatrics was suggested. The Secretary was instructed to notify Doctor Stadtmuller of the decision of the members to coöperate.

Following the reading of the correspondence, President Lewis brought up the discussion of a program for a campaign to defeat Proposition No. 2 (State Humane Pound Act). Literature from the California Society for the Promotion of Medical Research was distributed by the Secretary. Committees were formed to contact all service clubs within the county society limits and to make arrangements for talks before these bodies. On motion by Doctor Miller, seconded by Dr. Louis E. Jones, it was unanimously carried that the Secretary be authorized to have a half-page advertisement in each of the local papers, the cost of these advertisements to be paid out of the funds of the Society. There was considerable discussion regarding the splendid article and illustrations on antivivisection in the current issue of *Life*.

The Secretary was very much impressed by the alertness of the members of the Society as to the dangers of No. 2, and the evident enthusiasm for the defeat of this vicious bill.

* * *

The Placer County Medical Society held its annual meeting at the Freeman Hotel in Auburn on Saturday evening, November 5, Dr. C. E. Lewis, the president, presiding.

The Secretary's report and the Treasurer's report were read and accepted.

The application of Dr. Nathan A. Dubin of Lincoln, for transfer from the San Diego County Medical Society to the Placer County Medical Society was read for the second time. Doctor Dubin's application was unanimously accepted.

The following officers were elected to serve for the ensuing year: William M. Miller of Auburn, president; Lucas W. Empey of Roseville, vice-president; Robert A. Peers of Colfax, secretary-treasurer. Lucas W. Empey, as delegate, and Mildred E. Thoren, as alternate, hold their terms over for another year.

This being the annual meeting for the election of officers, no literary program was presented.

* * *

The Placer County Medical Society held a special dinner meeting at the Freeman Hotel in Auburn on Monday evening November 14, for the purpose of honoring our State president, Dr. W. W. Roblee of Riverside. President William M. Miller presided. In addition to the guest of honor, there were present eighteen members and also Dr. George H. Kress of San Francisco, Secretary of the California Medical Association and Editor of California

AND WESTERN MEDICINE; Dr. F. N. Scatena of Sacramento, Councilor for the Eighth District; and Dr. Walter E. Weddle of North Sacramento.

President Miller introduced our district councilor, Doctor Scatena. Doctor Scatena introduced President Roblee and President Miller introduced Doctor Kress.

Doctor Roblee outlined the work of the State Association, going into considerable detail regarding the various benefits to individual members because of their affiliation with the large State group. He sketched the history of the movement for socialized medicine in this country, including the activities of various Foundations, of the Federal Government, and of groups in this state. He portrayed the work that has been done by the State Association over a period of many years in an effort to develop a suitable plan for health insurance which would protect the best interests not only of the physician but also of the public whom the doctors serve. He also reported on the recent Council meeting of November 12 at which time a committee reported on a proposed plan for health insurance, sketching the highlights of the plan, which will be presented at a special meeting of the House of Delegates to be held in Los Angeles on December 17 of this year.

Doctor Kress elaborated on this plan and went into details regarding the benefits which will accrue not only to organized medicine but to the public. Among other topics discussed by Doctor Kress was the plan of the State Postgraduate Committee. He expressed the wish that a representative from our society be appointed in the formulation of plans for a postgraduate conference in this district. He closed his address with a strong plea to the members to call upon the Central Office for assistance at any time, stating that the Association Secretary was eager to be of service to the individual members as well as to the organization as a whole.

Doctor Scatena told of his experience in the Intercoast Hospitalization Insurance Association, pointing out some of the pitfalls of the health insurance work, as well as the benefits.

President Miller called upon Dr. L. W. Empey, vice-president of our society and our delegate. Doctor Empey expressed his views regarding the proposed plan and, in addition, asked a number of pertinent questions. As he is to be a delegate to the proposed meeting of the House of Delegates, he asked that a special meeting of the Placer County Medical Society be held prior to the meeting of the House of Delegates. Doctor Scatena stated that as soon as he received a digest of the contemplated plan which will be presented to the House of Delegates he would get in touch with the President or the Secretary and then a special meeting, mutually convenient, could be called.

Following Doctor Empey's remarks, the meeting was open for general discussion in which many of the members took part. It was the sense of those present that this had been one of the most interesting and illuminating meetings of our society.

The following motions were presented by the Secretary.

1. That it is the sense of the members of the Placer County Medical Society that they express their confidence in the State Association Council in its efforts to reach satisfactory conclusions regarding medical and hospital care for the low-income groups and that its individual members of the Placer County Medical Society pledge themselves to coöperate to the greatest possible degree toward the successful carrying out of the plans and conclusions as may be determined at the coming meeting of the House of Delegates on December 17. Seconded by Doctor March, and carried.

2. That President Miller be appointed as a Committee of One to represent the Placer County Medical Society in the plan to carry out postgraduate educational work in this district. Seconded by Doctor Empey, and carried.

ROBERT A. PEERS, *Secretary.*

SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by President Dave Dozier at the Auditorium on October 19.

There were ninety-eight members present.

Dr. Leo Eloesser, Clinical Professor of Surgery at Stanford University, gave a very interesting, as well as instructive, talk on his *Experiences in Spain During the Present Civil War.* Doctor Eloesser stressed the organization and equipment of the hospitals, as well as the types of war wounds encountered. The talk was illustrated with lantern slides, showing some of the hospitals established at the front and some of the ambulance units. The talk elicited many questions.

The applications for membership of Drs. A. F. Wallace and C. H. McDonnell were read for the second time and voted upon. Both were unanimously elected to membership in the Society.

Doctor Dozier discussed the present status of the Agricultural Workers' Health and Medical Association, now functioning in this area.

G. E. MILLAR, *Secretary.*

SAN BERNARDINO COUNTY

The annual meeting of the San Bernardino County Medical Society was held at Mapes Cafeteria in San Bernardino on Tuesday, October 11, at 7 p. m. There were eighty members and guests present.

President Williams explained the Council's feeling regarding a credit agency for the Society.

A motion was made and seconded that the men proposing to do the work of a credit agency be permitted to talk for ten minutes before the Society at the next meeting. Passed.

Dr. C. A. Love, Jr., made an announcement regarding the post cards for Dr. Walter S. Franklin, candidate for lieutenant-governor.

Dr. P. M. Savage, Sr., made a short address in behalf of Doctor Franklin's campaign. He also urged the members to defeat Proposition No. 2 (State Humane Pound Act).

The program of the evening was as follows: *Highlights of a Trip to Europe* by J. A. Champion of Colton; *Life—What Is It?* by A. B. Cooke of Los Angeles.

ARTHUR E. VARDEN, *Secretary.*

SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held in the clubrooms of the Medico-Dental Building, Stockton, on November 3. The regular meeting was preceded by the customary supper meeting at the Hotel Wolf.

The regular meeting was called to order by President A. C. Boehmer at 8:25 p. m.

A communication from the Metropolitan Life Insurance Company relative to reëndorsement of new standing orders for the Visiting Nurse Service was presented to the Society for endorsement. It was moved by Dr. Dewey Powell, seconded by Dr. Frank Doughty, that the question of endorsement of these standing orders be referred to the Board of Directors and their action be final. The motion carried.

Dr. Dewey Powell expressed thanks for the coöperation given by the Woman's Auxiliary to the San Joaquin County Medical Society in the distribution of literature on Proposition No. 2 (State Humane Pound Act). He especially commended Mrs. George Wever, President of the Auxiliary, on her splendid help.

The election of officers for 1939 were held, the following members being elected: Neill P. Johnson, president; Frank Vieira, first vice-president; R. L. Owens, second vice-

president; G. H. Rohrbacher, secretary-treasurer. Directors—J. O. Eccleston, G. K. Wever, V. R. Ross, H. C. Rixford, E. W. Hill, A. C. Boehmer, T. W. Kyddson, L. J. Peterson, and D. R. Powell. Delegates—G. H. Sanderson, Frank Doughty, and Dewey Powell. Alternates—C. A. Broaddus, C. V. Thompson, and R. T. McGurk.

Doctor Rixford introduced the speaker of the evening, Dr. Dave Rytand, who spoke on *Hypertension and the Present Status of Splanchnic Section*. This interesting paper was illustrated by many charts.

The meeting was declared adjourned at 10 p. m., and refreshments were served.

G. H. ROHRBACHER, *Secretary*.

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SAN MATEO COUNTY

The meeting of the San Mateo County Medical Society was held on Wednesday, October 26, in the banquet room of the Benjamin Franklin Hotel. Doctor Hartzell Ray presided.

The Chairman announced that Dr. Ivan T. Budaeff had been elected to membership in the Society at the last meeting of the Board of Directors.

The Secretary made an announcement concerning the work that was being done in an effort to defeat the State Humane Pound Act and expressed his appreciation to the Woman's Auxiliary for the excellent work that it had been doing. He urged all members of the Society not to overlook any opportunity to help kill this measure.

The Chairman announced the action of the Board of Directors at its last meeting concerning nominations of officers for next year, and on motion duly made, and seconded, the Society unanimously approved the action of the Board in making nominations at the October meeting and in presenting the nominations to the Society at its October meeting, owing to the fact that in November the Society was to meet jointly with the Santa Clara Society. The Chairman announced the following nominations made by the Board of Directors: Norman Morrison, president; Carl Benninghoven, vice-president; J. Garwood Bridgman, secretary. No other nominations being made, these members were declared elected.

The Chairman next introduced Mr. Harrison Call, Assemblyman from this district, who first briefly went over the twenty-five propositions to be voted upon in the November elections, presenting both sides of the question and discussing briefly the merits and demerits of the measures. Mr. Call discussed the *Nursing Practice Act* which is to be introduced in the Legislature at its coming session. In the course of his discussion he expressed his feeling, as a layman, that it might be advisable to have a doctor on the Board of Nurse Examiners instead of having an all nurse board, as was provided in the Act.

Doctor Benner expressed the feeling that the Act would place such stringent regulations on the practical nurses that it would be impossible for them to serve patients as they are now doing, and it would make it impossible for patients of limited means to have nursing care of any kind.

Mr. Call answered this observation by stating that practical nurses would be able to continue their work but would have certain restrictions placed on them which would be defined under the Act. The matter was referred to the Legislative Committee for study.

In connection with the proposed investigation of the San Mateo County Department of Public Health, the Chairman announced that the Board of Directors at its meeting in October had voted unanimously to request the San Mateo County Board of Supervisors to petition the United States Public Health Service for such a survey. The Secretary read a letter which had been sent to the Board of Supervisors on September 3, requesting action on the matter. He read a draft of a letter which had been prepared after the Board of Directors at its last meeting had reaffirmed its interest in an investigation and expressed its desire that the County Medical Society follow up the matter and again petition the Board of Supervisors to make the proper formal request required by the Federal Government.

Following the reading of these letters the matter was opened for discussion. Doctor Hanzlik discussed the situation at length, and in conclusion stated that, as a member of the County Medical Society, he felt the Society should go on record in favor of the survey. Doctor Murphy entered into the discussion and stated that he felt the Society should exercise some caution in going into matters of this sort without certain facts to show that a survey was necessary, and questioned the motives of the organizations which felt that an investigation was desirable. It was pointed out to Doctor Murphy by the Secretary that numerous civic bodies throughout the county—the Business and Professional Women's Club, the League of Women's Voters, the Ministerial Council, the University Women's Club, as well as the Labor Council—had definitely stated their stand and felt that there was urgent need for an investigation into the county health set-up. The Secretary further mentioned the attitude of the Board of Education which had recently met with the Public Health Committee, wherein one of its members expressed a lack of confidence in the County Medical Society, owing to the fact that it had taken no action nor announced any stand concerning the County Department of Public Health when there was considerable feeling on the part of the Board of Education, as well as numerous other interested bodies throughout the county to the effect that the County Health Department had failed grossly in the conduct of its duties. The Secretary expressed the opinion that the time had come when the County Society should take a definite stand and demonstrate its leadership in such matters as the present one if the Society proposed to occupy any significant place in county affairs, be they concerned with public health or otherwise. Doctors Knorp and Ray upheld the Secretary in this opinion.

Doctor Cleary reminded the Society of the existence of a Board of Health, established under the county charter, the purpose of which was to act as a committee between the County Department of Public Health and the County Medical Society and asked why the Board of Health had not been made acquainted with this particular problem. Dr. Norman Morrison answered that he was a member of the Board of Health and also sat on the Board of Directors in their discussion, and that he fully concurred with the Board on the action that had been taken.

Dr. Harper Peddicord then expressed the thought that the County Medical Society was not interested in having "some brain truster" come in with radical ideas concerning the conduct of a county department of public health. It was pointed out to Doctor Peddicord that the United States Public Health Service was not composed of "brain trusters" and that several members of the County Medical Society were acquainted with the caliber of men such as Doctor Ford and Doctor Gould, who were attached to the United States Department, and universally concurred in the opinion that, while these men might have their own personal ideas concerning a particular method of dealing with public health problems, at the same time they would conduct an accurate, scientific, fact-finding survey, the conclusions of which would be entirely up to the County Medical Society to reject or accept.

Dr. Ralph Howe expressed doubt concerning the value of the survey. To this remark it was answered that, irrespective of the results of any investigation, the County Medical Society would be grossly neglecting its duties if it failed to heed the demands of numerous civic and educational groups who, rightly or wrongly, felt that public health conditions in San Mateo County should be examined by an independent investigation. The Secretary was asked to re-read the draft of the letter he had prepared, and cer-

tain modifications were suggested. Doctor Benner made a motion that the Secretary be empowered to appear before the Board of Supervisors and read this letter to the Board. This motion was seconded, and passed unanimously.

J. GARWOOD BRIDGMAN, *Secretary.*

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TULARE COUNTY

A dinner meeting of the Tulare County Medical Society was held at the Hotel Johnson in Visalia on Sunday, October 23. Invitations to this meeting were sent to the Kings County Society and to the Woman's Auxiliary of the Tulare County Medical Society. The following members and guests were present: Dr. Ray Rosson, Dr. and Mrs. F. E. Hellbaum, Dr. and Mrs. F. R. Guido, Dr. and Mrs. W. C. Zeller, Dr. and Mrs. W. D. Parkinson, Dr. and Mrs. P. S. Barber, Dr. and Mrs. C. S. Ambrose, Coroner Roy Brooks, Doctors H. L. Falk, Frank Chamlee of Hanford, J. R. Filmore, Annie L. Bond, Dr. and Mrs. W. A. Winn, Dr. and Mrs. Leonard Carpenter, Dr. and Mrs. Karl F. Weiss, Dr. and Mrs. Ray Cronemiller, Doctors I. H. Betts, E. R. Zumwalt, L. Eloesser, R. S. Hardin, L. L. Seligman, I. M. Lipson, W. F. Burton, Dr. and Mrs. S. S. Ginsburg, Dr. and Mrs. Austin Miller, Dr. and Mrs. Ellis Sox, Dr. and Mrs. F. G. Powell, Dr. and Mrs. A. W. Preston, Dr. J. Seiberth, and Mesdames Gray, Tracy, Melvin, and guests.

The speaker of the evening was Dr. Leo Eloesser of San Francisco, who spoke on his *Experiences in the War in Spain.* The talk was illustrated by lantern slides. This was an unusually interesting address.

KARL F. WEISS, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (44)

Alameda County

Edgar C. Dawson

Butte County

J. Radford Linn

Los Angeles County

John A. Biggers
Edward W. Boland
Joseph F. Griggs
Robert Warner King
Clement J. Molony
David H. More
Ben A. Newman
Edward L. Sugar
John P. Vento
Richard Hugh Watt

Riverside County

Glen R. Halverson

Sacramento County

Curtis H. McDonnell
A. F. Wallace

San Francisco County

Ben Colloff
Charles Cuthbert Fahlen
Crane Gardenier
Louis Bruce Goldstein
Carl H. Hartwig
Eugenia L. Herron
George K. Herzog, Jr.
Francis T. Hodges
Jerome Konigsberg
Donald Roy Pratt
Manfred U. Prescott
Samuel Osipow
Miriam H. Rutherford
Minnola Stallings
Emil S. von Dessoneck

San Joaquin County

F. A. Dietrich
Phillip V. Lamb

San Mateo County

Ivan T. Budaeff

Santa Barbara County

Ralph M. Bell
Roland J. Brines
Donald M. Maxwell
James Harold Saint
Harold F. Tompkins

Santa Clara County

John Blum
Salvatore Campisi
J. Alison Cary
Leon Fox
Alexander Rogozen

Ventura County

James W. Moore

Transferred (2)

Lawrence M. Knox, from Monterey County to Alameda County.

Edwin A. Patterson, from Merced County to Alameda County.

In Memoriam

Bliss, Walter Parks. Died at Pasadena, November 4, 1938, age 49. Graduate of Columbia University College of Physicians and Surgeons, New York, 1916. Licensed in California in 1921. Doctor Bliss was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Gates, Mark Gorman. Died at Kernville, November 15, 1938, age 52. Graduate of University of California Medical School, 1910. Licensed in California in 1911. Doctor Gates was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Lancaster, Jesse Samuel. Died at Torrance. November 4, 1938, age 55. Graduate of Northwestern University Medical School, Chicago, 1910. Licensed in California in 1913. Doctor Lancaster was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Tobin, Peter Arthur. Died at San Francisco, November 21, 1938, age 57. Graduate of the University of Cincinnati College of Medicine, 1912. Licensed in California in 1914. Doctor Tobin was a member of the San Francisco County Medical Society, the California Medical Association, and the Americen Medical Association.

✣

Vecki, Victor G. Died at Berkeley, November 16, 1938, age 80. Graduate of Medizinische Fakultät der Universität Wien, 1881. Licensed in California in 1892. Doctor Vecki was a retired member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARIES

Edward Thomas Dillon
1877–1938

In the early hours of dawn, October 14, Dr. E. T. Dillon succumbed from an acute circulatory accident which came on suddenly some eighteen hours previously while he was on duty at St. Vincent's Hospital. By his death our community lost a true physician and a man of remarkable character.

Doctor Dillon, a native of Los Angeles, received his premedical education at the Los Angeles High School and old St. Vincent's College, which later became Loyola University. Upon receiving the degree of M. S. from St. Vincent's College in 1897, he matriculated in the School of

Edward Thomas Dillon
1877–1938

Medicine of the University of Southern California, located at that time on Buena Vista Street, now known as North Broadway. Dr. J. P. Widney was dean of the Medical School at that time, and prominent among the members of the faculty were Doctors George W. Lasher, Joseph M. King, and Claire W. Murphy, all of whom Doctor Dillon held in the highest esteem. Graduating in 1901 he served his internship under the superintendency of Dr. Ernest A. Bryant at Los Angeles County Hospital, which then supported but three interns. During his senior year in medicine, he also served as extern at the hospital, a position since abolished. Upon completion of his hospital service, he became Assistant to Dr. A. M. Smith, Police Surgeon. After pursuing special studies he entered practice, ultimately specializing in surgery. In the years following, up until 1910, he was associated with Doctors E. A. Bryant, F. K. Ainsworth, and H. G. Cates, surgeons for the Southern Pacific, Pacific Electric, and Los Angeles railways. He later became surgeon for the Southern Pacific Company, and was for more than twenty-five years surgeon for the Standard Oil Company, in the southwest area. He had also been surgeon for local councils of the Knights of Columbus.

Immediately upon graduation, he became associated with St. Vincent's Hospital, to which institution he was most loyally devoted throughout his entire career, serving as chief of staff and chairman of the Executive Committee. He possessed an inexhaustible determination to develop the highest type of scientific medicine in rendering service to the sick, and was among the pioneers in raising the standards of hospitalization. He participated in the work of the National Catholic Hospital Association and, in collaboration with Rev. C. B. Moulinier, contributed much to its development.

Though taking no active part in scholastic work Doctor Dillon nevertheless was a truly great teacher, with a rare ability to inspire the students and younger medical men. He was most devoted to his chosen profession and possessed an almost uncanny diagnostic ability. His loyalty to the sick was unbounded, and at times he was almost belligerent in his efforts in their behalf, and in the stimulation of his associates, entirely unmindful of his personal interests. In addition to his knowledge of medicine, he was endowed with a profound sense of the fitness of things in life and a remarkable philosophy. His associates eagerly sought and respected his counsel at bedside, in conference and personal relations.

The loss of a colleague possessed of such rare personality is keenly felt today by his numerous friends, but will only reach its real significance as time passes with the realization that his wisdom and comforting advice is lost to us.

Doctor Dillon was a member of the Los Angeles County Medical Association, California State Medical Association, American Medical Association, Pacific Coast Surgical Society, and the Clinical and Pathological Society of Los Angeles. He was also a charter member of the American College of Surgeons. He served with Dr. Granville MacGowan as co-chairman of the Appeal Board of the United States Army Draft, 1917–1918, and was counselor of the Los Angeles Chapter of the American Red Cross. He also held memberships in well-known civic and social associations and clubs. He was devoted to athletics in his college days, particularly football, playing upon teams of his high school, St. Vincent's College, and the Los Angeles Athletic Club.

He was born April 13, 1877, the son of Richard Dillon and Mary (Hennessy) Dillon. On January 29, 1907, he married Miss Laura Lynn Doran who survives with five children of the union: Edward T. Dillon, attorney; Richard Dillon, who is completing his medical course at Stanford University; Mary, Laura, and Katherine Dillon, all residing in the family residence, 4085 West Seventh Street, Los Angeles.

Funeral services were conducted October 17, from St. Vibiana's Cathedral with Solemn High Mass celebrated by his pastor, Rev. Victor Follen, and the memento being delivered by Right Reverend Monsignor John McCarthy. Interment was in Calvary Cemetery.

HENRY DIETRICH
FRANK J. BRESLIN
JOHN C. RUDDOCK.

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Emma Sutro Merritt
1856–1938

In the recent death of Dr. Emma Sutro Merritt the profession lost one of its pioneer women in medicine and the city lost one of its famous citizens, whose heart and money, most of her life, were centered in San Francisco and in the interests of the city she loved. Her death severed another link between this city and its golden past when, at the age of eighty-two, she succumbed from a year's illness. Doctor Merritt was born in San Francisco December 15, 1856, in what is now Chinatown. Her father, Adolph Sutro, prosperous pioneer merchant, lived there in a fine residence. A rich man's daughter, with no need for a vocation, and when few women had the courage to study medicine, she elected to choose our profession as a career.

She was educated in our schools, later graduated from Vassar, and entered what is now the University of California Medical School. Great and discouraging criticism was thrust upon her as a medical student by the resentful men, but one of them, George W. Merritt, defended her. They later were married in London in 1883, and attended the same medical schools abroad. Both practiced and taught medicine in this city, the husband until his death, the wife until her father's death in 1898 when she was called upon to shoulder the responsibility of acting as executrix of his vast estate.

Doctor Merritt had no children, but upon the death of her brother Edgar she adopted his son, Edgar, Jr., who with his two sisters, Marian and Rose, lived with her until her death. Doctor Merritt died in the famous family home at Sutro Heights above the Cliff House. With her death the city comes into complete possession of Sutro Heights. She was once offered a vast price for this property by William Wrigley, but refused the offer because of her love for her native city. In her passing our Society has lost a pioneer, a retired member, a noteworthy teacher, and a citizen known by many for her munificence.

H. M. F. BEHNEMAN.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION †

MRS. CLIFFORD A. WRIGHT.....President
MRS. FRED H. ZUMWALT.....Chairman on Publicity
MRS. FRANK H. RODIN..Assistant Chairman on Publicity

News Letter

Dear Auxiliary Members:

Congratulations to the members in each County Auxiliary who worked so hard and diligently to help defeat the antivivisection bill on the November ballot. The people have shown their appreciation of the need and importance of scientific medical research by voting against a legislative measure that would deprive them of the benefits of new discoveries in combating disease.

The radio has become one of the most important mediums of entertainment and education. The American Medical Association is using this means to entertain and educate the public in a very interesting program over the National Broadcasting Company's network entitled "Your Health."

There will be thirty-six broadcasts, one each week on Wednesday morning at 11 a. m. Pacific standard time. The first of these dramas was broadcast on Wednesday, October 19.

The theme is developed on such subjects as: Personal Health; How to Live; Let's Eat; Dodging Contageous Diseases; Health Tomorrow; Community Health; Health Education; Mothers and Children; Using Health Knowledge. For weekly titles please refer to the October issue of the *Hygeia Health Magazine*, page 938.

As these broadcasts are on what is known in radio as a sustaining basis, the time is furnished gratis by the radio network and local stations. No revenue is derived from the programs. Therefore, local stations may or may not take the program. If the radio station affiliated with the National Broadcasting Company in your community does not broadcast these programs, the County Auxiliary members may aid the American Medical Association by urging their local stations to take these programs.

Listen to these broadcasts yourself and ask your friends to listen.

Write to the National Broadcasting Company if you like the programs and to the American Medical Association if you do not, stating why.

Inform organizations about it: such as women's clubs, child study groups, Parent-Teacher Associations and schools.

In a recent issue of the San Francisco Board of Education bulletin, the programs, "Your Health," were recommended to the principals and teachers.

Let us all assist the American Medical Association in this educational and entertaining program by developing a large listening audience.

With most cordial holiday greetings.

Sincerely yours,

MRS. FRANK H. RODIN.

Component County Auxiliaries

Butte County

The Woman's Auxiliary to the Butte County Medical Association held its first fall meeting on Tuesday evening, October 18 at the home of one of its board members, Mrs. J. G. Hepplewhite, assisted by Mrs. P. L. Hamilton.

After reminiscing over the events of the past year, all the members agreed that the first year of the Auxiliary's existence was promising for the future. Although the activities were largely social, they provided many advantages.

Interesting plans were formulated for the winter. The women will meet at the homes of the respective members on the same evening that the doctors have their meeting at the hotel.

*

Contra Costa County

Although small in number and the distances between towns far, the Contra Costa County Auxiliary is fortunate in having a group of women who consider the effort worth while and are developing an interesting program.

The Auxiliary met on Tuesday evening, November 8, with eight members attending. This was a business meeting to discuss the program for the coming year. The membership decided that activities combining social and study features would be of most interest and value.

As Mrs. Allen Morrow of Richmond, vice-president, could not continue in office at present, Mrs. M. C. Bolender of Walnut Creek was elected to fill the vacancy.

Mrs. M. L. Stauffer of Pittsburg, president, and Mrs. Bolender were delegated to attend a meeting at the home of Mrs. William H. Sargent in Oakland on November 16, to discuss *What can the Auxiliaries do in a Philanthropic Way.*

The committee chairman for the campaign to defeat the antivivisection bill in the recent state election reported that much good work had been done.

After the business meeting the ladies joined the doctors in the hotel dining room for refreshments.

MRS. THOMAS J. DOZIER, *Chairman of Publicity.*

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Los Angeles County

The Los Angeles County Auxiliary was hostess to leaders of women's clubs to hear speakers on legislation and the need to defeat the State Humane Pound Act (Proposition 2).

The Auxiliary met for luncheon on Tuesday, October 25, at the Beverly Hills Hotel. There were 202 members and guests present.

The president, Mrs. William H. Leake, presided and introduced the following guests from the speaker's table: Mrs. Clifford A. Wright, president Woman's Auxiliary to the California Medical Association; Mrs. George H. Cook, past president, Ebell Club; Mrs. Abraham Lehr, president Crippled Children's League; Mrs. Lichtenwater, president Woman's Auxiliary to the Los Angeles County Dental Association; Mrs. Catherine Moore, Cosmos Club; Mrs. Catherine Cornell, chairman of legislation, Woman's Auxiliary to the Los Angeles Chamber of Commerce; Mrs. John Raven, vice-president, Catholic Women's Club; Mrs. Louise W. Watkins, past president, Friday Morning Club.

Dr. John W. Crossan, Mr. Ben Read and the Reverend R. Anderson Jardine were the guest speakers. Their subjects were *Legislation and the Need to Defeat the Humane Pound Act.*

An appeal was made by a representative of the Community Chest who also commended the medical profession for the charitable work done throughout the year.

Mrs. John Martin Askey, Chairman of Legislation, reported that her committee had worked day and night to defeat the antivivisection bill. Members of the committee contacted practically every club in Los Angeles County to urge that they have a speaker on the subject and at-

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Frank H. Rodin, Assistant Chairman of the Publicity and Publications Committee, 2457 Bay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Rodin and must be sent to her before publication takes place in this column. For lists of state, and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

tended all meetings to distribute pamphlets and literature. Circulars, cards, letters, and pamphlets were distributed to all doctors' offices to be mailed by them to their patients.

Mesdames Raphael Dunlevy and Samuel D. Ingram were in charge of reservations and Mesdames Dougherty and Irish arranged the floral decorations.

On Tuesday, December 13, Mrs. William H. Leake, president, will entertain the entire membership of the Woman's Auxiliary to the Los Angeles County Medical Association at tea in her home at Beverly Hills.

MRS. KARL O. VON HAGEN, *Chairman of Publicity.*

Orange County

The November meeting of the Woman's Auxiliary to the Orange County Medical Association was held at the Anaheim Ebell Club with thirty members and guests present. The president, Mrs. Hiram Currey, presided.

Mrs. K. H. Sutherland, program chairman, introduced Mrs. E. H. Crawford, secretary of the Orange County Tuberculosis Association, who showed two films: *Let My People Live* and *Diagnostic Procedures.* Dr. K. H. Sutherland, County Health Officer, reviewed the films and discussed the tuberculosis situation as it existed in Orange County.

At the close of the meeting refreshments were served from a beautifully appointed table decorated in fall colors. The hostesses of the day were Mesdames L. W. Wilson, E. J. Steen, Claude Steen, John Wood, H. A. Johnston, H. C. Nelson, Ralph Duncan, and Glen Curtis.

MRS. G. WENDELL OLSON, *Publicity Chairman.*

Riverside County

The first regular meeting of the Woman's Auxiliary to the Riverside County Medical Association was held on October 10, at 8 p. m., at the Riverside Community Hospital. The president, Mrs. W. W. Roblee, presided with twenty members and prospective members present.

A very interesting and helpful discussion of Amendment No. 2, the Humane Pound Act, was given by Dr. B. O. Raulston, of the University of Southern California.

Plans for the coming year were discussed and following the business meeting a social hour was enjoyed. The doctors joined the ladies for refreshments, which were served by Mesdames A. W. Walker, C. R. Geith, A. W. Miller, and H. L. Ratliff.

MRS. T. A. CARD, *Secretary.*

Sacramento County

Community service will be the purpose of the winter activities of the Woman's Auxiliary to the Sacramento Society for Medical Improvement, it was announced at the October meeting held at the home of Mrs. Donald McNeil. The president, Mrs. George Spencer, presided.

Members will assist in Red Cross work, Christmas tuberculosis seal distribution, activities of the Better Films Board, and the support of the Home for Crippled Children.

Mrs. Norris Jones, program chairman, introduced Dr. W. J. Ven Den Berg, local physician, and Mr. Ben Read, executive secretary of the California Public Health League, who discussed the *Humane Pound Act and Health Legislation.*

Mrs. John D. Lawson and Mrs. Ruth Dunlap presided at the tea table, and were assisted by Mesdames Orrin Cook, Hans Schluter, J. H. Yant, and Donald McNeil.

MRS. D. S. PULFORD, *Chairman of Publicity.*

San Diego County

The members of the newly organized Woman's Auxiliary to the San Diego County Dental Society were the guests of the Woman's Auxiliary to the County Medical Association at their luncheon meeting which was held October 17, at the University Club. There were nineteen guests and forty-one members present.

Dr. L. C. Kinney was the guest speaker, who gave a very interesting talk on *Legislation.*

MRS. H. K. ALBERTSON, *Publicity Chairman.*

San Francisco County

The regular meeting of the San Francisco County Woman's Auxiliary was held on November 15, at 1:30 p. m., in the beautiful home of the San Francisco County Medical Society. The president, Mrs. Thomas E. Gibson, presided, with about eighty members present.

The guest speaker, Dr. George Warren Pierce, spoke on *Cosmetology and Plastic Surgery,* demonstrated with lantern slides.

The standing committees reported on the progress of work done in their respective departments.

The committee composed of members who had volunteered their services to work to defeat the Humane Pound Act on the November ballot served unceasingly for days. Thousands of stickers were pasted on pamphlets. Circulars, letters, and cards were distributed to all the doctors, dentists, and clinics in the county.

After the business meeting, tea was served in the library to members and guests. An interesting arrangement of fruit centered the beautifully appointed tea table. Mrs. Clain F. Gelston and Mrs. John D. Humber and their committee were the hostesses of the day.

MRS. CLAIN F. GELSTON, *Publicity Chairman.*

San Joaquin County

The attendance of the meetings of the Woman's Auxiliary to the San Joaquin County Medical Association is gradually increasing was reported at the November meeting held at the home of Mrs. J. W. Barnes. The president, Mrs. George K. Wever, presided, with twenty-one members present.

The speaker was Mrs. A. P. Harrison, chairman of legislation of the League of Women Voters. *Legislative Initiatives on the November Ballot* were discussed.

MRS. GEORGE K. WEVER, *President.*

Santa Barbara County

A joint meeting of the Santa Barbara County Medical Society and the Woman's Auxiliary was held on the evening of October 10 at the Bissell Auditorium of the Cottage Hospital.

The guest speaker was Dr. Louis Packard of Bakersfield, who spoke on the *Evils of the Humane Pound Act.*

After Doctor Packard's talk, the members of the Auxiliary held their business meeting in an adjoining room. New chairmen of the various committees were appointed as follows: Mesdames Alfred Wilcox, Program; Richard McGovney, Hygeia; Harry DeVighne, Girl Scouts; C. Z. Nicholas, Telephone; William R. Hunt, Membership; C. T. Roome, Hospitality; C. W. Henderson, Publicity. The Auxiliary will, as usual, sponsor a table at the Red Cross campaign.

Mrs. Van Paing, chairman of the Essay Contest Committee, reported through the president that thirty essays were submitted by the pupils of the Santa Barbara Junior High schools last June. Two prizes of $5 each were given to the pupils who wrote the best essay on any article chosen by them from the *Hygeia Health Magazine* during 1938. These pupils attend the Carpinteria and Lompoc schools in Santa Barbara.

Preceding the meeting at the auditorium, the officers of the County Medical Society and the Woman's Auxiliary, their wives and husbands gathered for dinner at the El

Paseo and had as their guests Doctor and Mrs. Lindsay of Pasadena and Doctor and Mrs. Packard of Bakersfield.

MRS. C. W. HENDERSON, *Publicity Chairman.*

Santa Clara County

The Woman's Auxiliary to the Santa Clara County Medical Association entertained three state officers at their November meeting. The members and guests met for luncheon at the La Molle House restaurant.

The president, Mrs. M. D. Baker, presided and introduced the guests: Mrs. Hobart Rogers, junior past president of the State Auxiliary; Mrs. Lawrence M. Knox, councilor for fifth district and chairman for the convention of the Woman's Auxiliary to the California Medical Association to be held next May at Del Monte; and Mrs. William H. Sargent, who was the state officer that organized the women of Santa Clara County into an Auxiliary in 1934.

Mrs. Russell V. Lee, program chairman, introduced the guest speaker, Mr. E. M. Smith of San Francisco, who spoke on *Medical and Hospital Insurance.*

Santa Cruz County

The Woman's Auxiliary to the Santa Cruz County Medical Society met at the home of the president, Mrs. Alfred L. Phillips, Monday, October 31, with eleven members present.

Each member distributed literature on the Humane Pound Act to the women's clubs in Santa Cruz County and to their friends and neighbors.

MRS. R. C. ALSBERG, *Recording Secretary.*

Tulare County

Sunday, October 23, the members of the Tulare County Medical Society and the Woman's Auxiliary met for dinner and had as their guest, Dr. Leo Eloesser of San Francisco.

The speaker of the evening was Doctor Eloesser, whose subject was: *The Organization of Medical Units in Spain.*

This meeting was the most successful and had the largest attendance since the organization of the Auxiliary.

MRS. W. B. PARKINSON, *Corresponding Secretary.*

United States Institute of Health.—From director and two attendants stationed in a single Marine Hospital room at Staten Island, to director plus 728 assistants (and 168 active, nonresident consultants), housed in six vast buildings in a sixty-acre greenwood near Washington, D. C.—such has been the physical growth of the National Institute of Health, major research division of the United States Public Health Service, in the half-century since its founding in 1887.

While the Institute is its most important research laboratory in size and number of employees, it must not be thought of as the only such laboratory conducted by the Service.

"A number of temporary laboratories have been set up in the field for various investigations," explained Dr. A. M. Stimson, Medical Director, United States Public Health Service, in "A Brief History of Bacteriological Investigations of the United States Public Health Service" (Supplement 141 to the Public Health Reports), "and the Marine Hospitals are all provided with clinical laboratories in some of which research has been conducted.

"In addition, a plague laboratory has been maintained almost continuously in San Francisco since the first outbreak of plague there. A laboratory for the study of spotted fever and other diseases, at Hamilton, Montana, has been in almost continuous operation since the Service became interested in spotted fever in that state; and a laboratory for the exclusive investigation of stream pollution and sewage disposal has been in operation at Cincinnati for many years. Research work on leprosy has been conducted at Honolulu, the island of Molokai, and the leprosarium at Carville, Louisiana."

Laboratories for the investigation of malaria are located at Columbia, South Carolina, and Savannah, Georgia. Recently a laboratory for investigation of yellow fever problems has been established in Miami, Florida.

Throughout his detailed description of public health problems investigated inside and outside of these laboratories, Doctor Stimson has woven into his review of fifty years of medical progress a background of history of men and institutions which makes the report a valuable and interesting handbook, both to the layman and scientist. Thirty-eight separate divisions take up the bacteriological work done by Public Health Service researchers in fields varying from "Anaphylaxis" (the causes and prevention of reactions to inoculation) through "Anthrax," "Leprosy," "Milk," and "Psittacosis," to "Shellfish." In connection with each division, references are given both to the scientists mainly concerned in the studies and their major contributions.

Under the heading "Plague," is retold the story of "the sordid and distressing annals lasting over many months, extending to the city and state governments, into local politics, the press, the agencies of the law, and even threatening international complications."

"It is thus within the power of a few microscopic plants on a glass slide, granted certain antecedents," says Doctor Stimson, "to cause such upheavals in the affairs of man. The health agencies appear from the record to have come through the melee with at least honor unimpaired, but the political agencies and the press made but a poor showing in the cause of public service. Even the law, which we must not criticize, gave an example of how decisions arrived at, presumably in accordance with its rules and traditions, may protect undeserving persons and do the public an enormous disservice."

Longer sections are devoted to "Water," and "Control of Biologics." The first reviews the important part the Service has played in bringing about measures responsible for the marked reduction in water-borne diseases since it began its studies in the early 1890's. The latter deals with those "bacteriological activities incidental to the legal control of the manufacture and sale of products used in the prevention and treatment of human diseases, such as serums, vaccines, viruses, and the like." Subsections here take up matters of anaphylaxis in further detail, and unconfirmed "cures."

"Yellow fever," Doctor Stimson declared, "was familiar to officers of the Marine Hospital Service previous to its reorganization (as the Public Health Service) as a visitation which they encountered in their tours of duty at Atlantic and Gulf coast stations and on the Mississippi River. They witnessed it, diagnosed it on clincal evidence, treated it, some of them contracted it, and a few died of it. It was, however, a medical rather than a public health problem with them until after the reorganization of the Service in 1870, and especially after the quarantine acts of 1890 and 1893, when it became a responsibility and a nightmare."

There follows a brief history of this once-terrifying scourge which first appeared on American soil in 1668.

The record ends with a passing tribute to the names of six obscure Service doctors who died of yellow fever, martyrs to science "at the very beginning of their medical careers."

Few of us take the pains to study the origin of our cherished convictions; indeed, we have a natural repugnance to so doing. We like to continue to believe what we have been accustomed to accept as true, and the resentment aroused when doubt is cast upon any of our assumptions leads us to seek every manner of excuse for clinging to them.

The result is that most of our so-called reasoning consists in finding arguments for going on believing as we already do.—Bourne.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, St. Louis, Missouri, May 15 to 19, 1939. Olin West, M.D., Secretary, 535 North Dearborn Street, Chicago, Illinois.

California Medical Association, Hotel Del Monte, May 1 to 4, 1939. George H. Kress, M.D., Secretary, 450 Sutter Street, San Francisco.

Medical Broadcasts*

Los Angeles County Medical Association

The radio broadcast program for the Los Angeles County Medical Association for the month of December is as follows:

Thursday, December 1—KECA, 10:45 a. m., The Road of Health.
Saturday, December 3—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, December 8—KECA, 10:45 a. m., The Road of Health.
Saturday, December 10—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, December 15—KECA, 10:45 a. m., The Road of Health.
Saturday, December 17—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, December 22—KECA, 10:45 a. m., The Road of Health.
Saturday, December 24—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.
Thursday, December 29—KECA, 10:45 a. m., The Road of Health.
Saturday, December 31—KFI, 9:00 a. m., The Road of Health; KFAC, 11:30 a. m., Your Doctor and You.

Truisms: From the Pen of the Late Joseph P. Widney, Founder of the Los Angeles County Medical Association.—Boake Carter, feature writer for the Hearst newspapers, on November 17 printed excerpts from the works of the late Joseph P. Widney, whose death, at the age of 97, occurred during the current year. Biographical and other sketches of Doctor Widney have appeared in CALIFORNIA AND WESTERN MEDICINE.† The following comments by Boake Carter are of interest:

" 'Here is a platform, composed of a number of planks for the preservation of popular government. The truths that must be learned are these:

'That labor is a blessing, the greatest ever given to man, and not a curse.

'That the right to labor and to become a producer is the birthright of every human being, a right not to be questioned or denied.

'The idle man, whether behind prison walls or on a strike or subsisting on inherited wealth, is fed in his idleness by someone's toil. That there is no such thing as the bread of idleness; it is the bread of industry, only eaten by idleness, and that community is the poorer for every mouthful thus eaten.

'That artificially hampered or restricted production reacts inevitably and disastrously upon the producer whether he be employer or employee, the working of the natural law of supply and demand being the only safe and healthful guide.

'That there is no mysterious power in the state. It is only the people—aggregated; not an entity in itself.

'That the state is no wiser than the individual members who compose it.

'That law cannot create wealth; only regulate it.

'That capital is only a credit mark for labor done, and which has not been consumed; labor only unaccumulated capital and which if not consumed may become capital.

'That labor and capital mutually supplement each other, and that to each a higher grade of living is possible because of the other.

'That while an honest day's labor is entitled to the honest dollar, equally true is it that the honest dollar is entitled to the honest day's labor.

'That an injustice to one is a wrong to all.

'That when a community permits violence, it is sapping the foundations of its own safety. License paves the way for despotism; and the demagogue is only the forerunner of the dictator.

'That every dollar's worth of property destroyed by riot is so much of the world's stored-up labor blotted out, and the rioter himself, as a member of the community, is that much poorer.

'That the man who promotes class jealousies is an enemy to all, and to himself as well; and that the labor union demagogue is the same pestilent creature, and in the end just as harmful to the causes he espouses as is the political demagogue.

'That no man and no class is permanently lifted up by pulling another down. The ties of the world-life are too closely interwoven for this.

* * *

" 'The above truisms were written in 1907. They fit perfectly the picture of 1938. I found them when desiring to learn something about the term 'Aryan,' about which Hitler has tub-thumped so much. They are contained in 'Race Life of the Aryan People,' of the Old World and New World, two volumes by Joseph Widney. He was a medical officer in the United States Army. He wrote them twenty-five years before anyone ever heard of a man named Hitler! They are not only fascinating, but uncanny.' "—*Los Angeles Examiner*, November 17, 1938.

American Board of Obstetrics and Gynecology: Examinations.—The next written examination and review of case histories for Group B candidates will be held in various cities of the United States and Canada on Saturday, February 4, 1939, at 2 p. m. Application for admission to this examination must be filed on an official application form in the office of the secretary at least sixty days prior to this date (or before December 4, 1938).

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in St. Louis, Missouri, on May 15 and 16, 1939, immediately prior to the annual meeting of the American Medical Association. Application for admission to Group A examinations must be on file in the secretary's office by March 15, 1939.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

† Issues of April, 1936, page 292; August, 1938, page 161.

Scientific Exhibit: American Medical Association.—Application blanks are now available for space in the Scientific Exhibit at the St. Louis session of the American Medical Association, May 15-19, 1939. Attention is called to the fact that the meeting is a month earlier than usual, and applications close on January 5, 1939. Blanks will be sent on request to the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

Mechanical Heart Will Beat for San Francisco Fair Visitors.—The ceaseless motion of the heart—from the cradle to the grave, at the rate of seventy beats to the minute—will be dramatically demonstrated to millions of visitors to the 1939 Golden Gate International Exposition on San Francisco Bay. The display will be part of the exhibit of the Ciba Pharmaceutical exhibit in the Hall of Science.

Over two billion heart beats—the equivalent of seventy beats per minute over a 65-year period—will be indicated on a three dimensional model heart which stands five feet high in the center of the exhibit. Lights flashing over other models will trace the course of the blood flow, the movements of the valves. Supplementary drawings and animated models will explain:

How the heart pushes forward one gallon of blood per minute when a person is in a resting position; three gallons when standing, and thirty gallons when running.

How the arteries and veins contract and expand, how the pulse is created, and how valves function in stopping back-flow.

How the blood stream provides food to the cells, removes waste matter.

How the red blood cells supply oxygen to the body, and how the white cells provide protection against invading bacteria; how blood platelets act in the formation of clots, shown on a model enlarged 10,000 times.

How the heart itself is supplied by blood to enable it to carry on its pumping functions.

The danger of inflammation will be emphasized, showing how efficiency of the heart is reduced. Popular misconceptions of high blood pressure, too, will be outlined and explained along with heart disease, its prevention and treatments for relief.

Doctors' Bills.—Recognizing the fairly widespread tendency on the part of the public to regard doctor bills as obligations that can wait indefinitely or at least until after all other bills have been paid, California Bank, Los Angeles, during the week of October 31 to November 5, inaugurated "Pay Your Doctor Week," with three-column six-inch ads in local metropolitan daily newspapers and reprints of the ad in approximately 35,000 month-end checking account statements calling attention to the dedicated week and to the bank's personal loan plan for paying doctor and other bills.

To each of the five thousand doctors and dentists practicing in the communities served by the institution's fifty-four offices, California Bank sent an explanatory letter printed on the reverse side of a reprint of the ad along with a folder describing the bank's personal loan plan.

Quoting from the letter:

" 'Pay Your Doctor Week' is designed to help you turn your accounts receivable into cash and to provide your patients with a convenient, low rate, installment method of paying their bills. . . . We shall appreciate having an expression of your opinion and any suggestions you care to offer concerning 'Pay Your Doctor Week.' . . . Your opinion, as part of a consensus of the medical and dental fraternity, will assist us in determining whether or not 'Pay Your Doctor Week' should be repeated. Please address any communication you care to make to California Bank (Room 1207), 625 South Spring Street, Los Angeles."

Los Angeles Clinical and Pathological Society.—The dinner meeting held on Wednesday evening, November 16, at 6:30 o'clock, in the California Club, was in honor of charter members and in commemoration of the thirty-fifth anniversary of the founding of the Society.

Dr. George Herrmann, Professor of Medicine, University of Texas, was the guest speaker, and discussed "The Clinical Nature of Heart Failure."

Southern California Medical Association.—The ninety-ninth semi-annual meeting was held on October 28 and 29, with headquarters in the Los Angeles County Medical Association, 1925 Wilshire Boulevard, Los Angeles. The program follows:

Friday Afternoon Session:

Notes on the Early and Late Treatment of Wounds by William S. Kiskadden of Los Angeles, with discussion by James B. Johnson and John D. Gillis, both of Los Angeles.

Symposium on heart disease, with case reports, as follows:

An Unusual Circulatory Accident by Lewis T. Bullock of Los Angeles, with discussion by Robert W. Langley of Los Angeles.

Subacute Bacterial Endocarditis Simulating Syphilis by George H. Houck of Los Angeles, with discussion by Willard J. Stone of Pasadena.

Myocardial Damage Following Administration of Emetin by A. M. Roberts of Los Angeles, with discussion by Franklin R. Nuzum of Santa Barbara.

Paroxysmal Tachycardia by William P. Corr of Riverside, with discussion by Arthur M. Hoffman of Los Angeles.

Epilepsy: The Diagnosis, Cerebral Localization and Treatment by William T. Grant of Los Angeles, with discussion by M. A. Glaser and Leo J. Adelstein, both of Los Angeles.

Friday Evening Session:

Modern Concepts of Mental Hygiene by Lloyd H. Ziegler, Associate Medical Director of Milwaukee Sanitarium, Wauwatosa, Wisconsin.

Saturday Morning Session:

Mucocele of the Appendix by James C. Doyle of Los Angeles, with discussion by Harlan Shoemaker and Shuler F. Fagan, both of Los Angeles.

Reactions Following Blood Transfusions by Milo K. Tedstrom of Santa Ana, with discussion by Roy W. Hammack of Los Angeles and Alvin G. Foord of Pasadena.

The Treatment of Milder Psychiatric Disorders at Home by Lloyd H. Ziegler of Wauwatosa, Wisconsin, with discussion by Glenn E. Myers of Compton and William Edler of Pasadena.

The Hemorrhagic Tendency in Patients with Jaundice by Edward W. Boland of Los Angeles, with discussion by C. J. Berne of Los Angeles and P. A. Gray of Santa Barbara.

Saturday Afternoon Session:

The Value of Splenectomy by Donald C. Collins of Los Angeles, with discussion by V. C. Hunt of Los Angeles and Leo J. Madsen of Santa Monica.

Symposium on Pulmonary Tuberculosis, with case reports, as follows:

Closed Intrapleural Pneumonolysis by John C. Jones of Los Angeles, with discussion by Edwin S. Bennett of Olive View.

Extrapleural Pneumothorax by Marvin S. Harris of Los Angeles, with discussion by Frank S. Dolley of Los Angeles.

Pneumoperitoneum by E. E. Noble of Los Angeles, with discussion by Edward W. Hayes of Monrovia.

Pneumothorax by R. H. Sundberg of San Diego, with discussion by Carl R. Howson of Los Angeles.

The Disturbed Physiology in Bronchial Asthma: Its Therapeutic Implications by Hyman Miller of Los Angeles, with discussion by Charles C. Coghlan, J. Dwight Davis, and Robert W. Lamson, all of Los Angeles.

Officers for 1938 are: William H. Barrow of San Diego, president; Alvin G. Foord of Pasadena, first vice-president; William P. Corr of Riverside, second vice-president; John B. Doyle of Los Angeles, secretary-treasurer.

Councilors are: Frank R. Nuzum, Santa Barbara; Robert W. Langley, Los Angeles; Merrill W. Hollingsworth, Santa Ana; William H. Barrow, ex officio; and John B. Doyle, ex officio.

Board of Governors includes: F. M. Pottenger of Los Angeles; Egerton L. Crispin of Los Angeles, Joseph M. King of Los Angeles, Joseph K. Swindt of Pomona, Charles T. Sturgeon of Los Angeles, Paul E. Simonds of Riverside, Raymond G. Taylor of Los Angeles, Fred B. Clarke of Long Beach, Carl R. Howson of Los Angeles, Bon O. Adams of Riverside, and H. Douglas Eaton of Los Angeles.

Subject: Legal Status of Physicians under the Workmen's Compensation Act of California.—An item and brief on this important subject appears in the advertising section of this issue, commencing on advertising page 26.

University of California Medical School.—The University of California Medical School will offer a course on "The Treatment of Fractures" from December 14 to 16. Through the courtesy of Dr. J. C. Geiger, Director of Public Health, this will be given at the San Francisco Hospital. The course, which will be short and comprehensive, has been designed to meet the needs of physicians engaged in private practice. Through clinical presentations, detailed outlines of treatment and demonstrations, every effort will be made to make the course applicable to the problems encountered in practice. Upon request, the dean's office, University of California Medical School, Medical Center, San Francisco, will be glad to supply more detailed information.

Second Federal Institution for Drug Addicts.—The United States Public Health Service Hospital for drug addicts at Fort Worth, Texas—second such institution in the country—was formally dedicated on October 28.

Passed Assistant Surgeon William F. Ossenfort was assigned to duty as medical officer in charge of the hospital in April of this year. Since that time, with the aid of a skeleton staff, he has been actively engaged in equipping and preparing the hospital for patients.

Built at a cost of approximately $4,000,000, the institution covers 1,400 acres. It includes an administration building, a clinical ward building, a maximum custody ward, personnel residences, and maintenance structures. A prolonged treatment building for the more advanced cases of addiction will be ready in 1939. About three hundred beds already have been set up for patients scheduled to occupy the new quarters beginning the week following dedication.

Comparable in function with the original hospital at Lexington, Kentucky, the new unit differs somewhat in design and arrangement. Structurally, it has less emphasis placed on the custodial features. Artificial barriers such as bars, high gates, and walls, and the enclosed court feature are less pronounced.

Composition of Neutron Ray.—The neutron ray, now claiming wide attention as a therapeutic agent, particularly in the treatment of malignant growths on animal tissues, is described in nontechnical language by Dr. Luis W. Alvarez, research fellow in physics in the Radiation Laboratory of the University of California. The comparative effects of neutron and x-ray radiation are now being studied by the University with the hope of developing the neutron ray as an important adjunct to the other types of radiation.

The ray is produced by the University's cyclotron or "atom-smashing" machine. The apparatus is usually adjusted to produce eight million volt hydrogen atoms, and these are, in turn, directed at some substance, for example, iron. Some of the iron atoms are transmitted into new elements, either cobalt or manganese, while other iron atoms are changed into a new form of iron which has many of the properties of radium. This new form of the metal is known as radio-active iron.

Similarly, if the atomic bullets are directed at any other substance, they will cause transmutations to occur, and, in many of the cases, radio-active products will be formed.

When the high-speed atom collides with the atom of the "target substance," the latter explodes and flies into two parts. One of these parts is the atom of the new element, for example, cobalt, manganese or radio-active iron, and the other is a light atom, such as hydrogen or helium. More often than either of these two, it is a new particle known as a neutron.

The neutron was discovered in 1932, and is an electrically neutral body of about the same weight as the hydrogen atom. The fact that it carries no electrical charge enables it to penetrate far into the interior of large bodies of matter where ordinary radiation, such as light, x-rays or radium cannot go. It is the ray caused by the neutron discharge from the cyclotron which appears to have increased the lethal power of radiation on the tumor masses in animal experimentation.

Mississippi Valley Medical Society 1939 Essay Award.—The Mississippi Valley Medical Society offers a cash prize of $100, a gold medal and a certificate of award for the best unpublished essay on a subject of interest and practical value to the general practitioner of medicine. Entrants must be members of the American Medical Association. All contributions *must not* exceed 5,000 words, be typewritten in English in manuscript form, submitted in five copies, and must be received *not* later than May 1, 1939, Further details may be secured from Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Building, Quincy, Illinois.

Another Near Miracle Credited to "Iron Lung."—A man named Drinker and a few alley cats have been given credit by the University of California Hospital for granting a new lease of life under almost miraculous conditions to a seventeen-year-old Chico boy. Some weeks ago, while in the last stages of meningitis, complicated by a spinal abscess, the boy was rushed by automobile from his home to the University of California Hospital in San Francisco. Upon arrival he had fallen into a deep stupor, a complete paralysis from the arms down had set in and death seemed but minutes away.

Frankly informing his parents that the case seemed hopeless, the physicians had the boy placed in an improved mechanical respirator and, after two weeks, he had so improved that he could be taken from the respirator. The abscess was drained, relieving him in part of the paralytic condition. While he is not yet out of danger the physicians in charge give him a good chance for recovery.

The boy is David Burnell Van Dyke of 406 Cherry Street, Chico. He became ill over a month ago, and despite heroic local treatment, he sank rapidly. The trip to San Francisco in the family car was decided upon as a last desperate expedient, the parents being in straitened circumstances and unable to afford an ambulance for the long trip. Doctors and technicians at the University Hospital unanimously agreed that the case was one of the most hopeless ever brought to their attention, the ravages of the two quick-acting and often fatal diseases being aggravated by the ordeal of the long journey from home.

The attending physicians pass most of the praise on to Doctor Drinker, dean of the school of public health of Harvard University, who devised the respirator, or iron lung as it is called, tried it out in its crude form on the cats, which had become afflicted with a severe respiratory disease, and found that it worked in a manner little short of miraculous. Experiments on human cases proved equally effective.—*University of California Clip Sheet.*

Fatal Dog Disease Reported Checked by University of California Foundation.—An endemic of Weil's disease or "yellows," a fatal disease of dogs, which has claimed the lives of hundreds of canines throughout the state and endangered many human beings as well in the past two years, has been definitely checked, it is announced by the Hooper Foundation for Medical Research of the University of California. So severe had the depredations of the disease on the dogs of San Francisco become that a veterinarian of

the Society for the Prevention of Cruelty to Animals appealed to the Foundation for aid. The Society reported 80 to 90 per cent mortality among the dogs attacked. To this plea were added those of a number of veterinarians in Stockton and elsewhere.

Recently two human cases of the disease were contracted in California, presumably through the handling of dogs. Both were veterinarians, one in San Francisco and the other in Stockton. Both passed through a long and serious course of illness before recovery. Numerous other cases of human attack were reported, one fatal, but the infection could not be directly traced to dogs.

The nature of the disease was established in the laboratories of the Hooper Foundation, where it was determined that a spirochete, technically called the Leptospira, was the causative factor. Simultaneous studies had established that the disease or one of its close relatives had been prevalent in Holland at one time, and had been checked by a certain serum developed there. Quantities of this serum were obtained and this, together with serum obtained from convalescent dogs, was used for the California outbreaks. The latest reports state that the treatment has been generally successful.

The serum is obtainable at the Hooper Foundation at the present time, where it may be obtained by all qualified veterinarians. It is hoped to have it placed on the market within the next few months.

Warning has been sent the veterinarians of the state to watch not only for the infection in dogs but for human infection as well, and to report all cases at once to the Hooper Foundation.

Symposium on Mental Health.—The Section on Medical Sciences of the American Association for the Advancement of Science announces a Symposium on Mental Health to be held in conjunction with the annual meeting of the association at Richmond, Virginia, from December 28 to 30, 1938, and cordially invites the attendance and participation of all interested persons.

A Coöperative Project

Collaborating in the plans for the event are the American Psychiatric Association (an affiliated body of the American Association for the Advancement of Science, the United States Public Health Service, the Mental Hospital Survey Committee (composed of representatives of eight national medical bodies), the National Committee for Mental Hygiene and a special committee of eminent psychiatrists who are developing the program for the symposium under the chairmanship of Dr. Walter L. Treadway, formerly assistant surgeon general of the Public Health Service.

Purpose of the Symposium

The symposium will provide an unusual opportunity to bring the great problem of mental health before the forum of the American Association for the Advancement of Science and, through it, to the scientific and lay public of America. It will be the tenth in the series of symposia held by the Section on Medical Sciences since 1934 and the first to deal with this important subject. All who have a serious interest in the subject will be welcome—scientists and laymen, professional workers and others—for the mental hygiene movement is a *public movement,* including among its adherents representatives from all walks of life and courting the good-will and support of all in its far-reaching aims and activities.

Its object will be, essentially, to present a synthesis of existing knowledge of the mental health problem, to evaluate past experience, crystallize aims and objectives and to marshall the scientific forces of the nation for a concerted, coördinated and more effective attack on mental disorders and disease. By drawing on the various scientific disciplines, within and without the field of mental hygiene, that are in a position to contribute new knowledge, we hope to light up the problem as never before and to arrive at a new and better orientation in dealing with it on its practical as well as theoretic side.*

Press Clippings.—Some news items from the daily press, on matters related to medical practice, follow:

Absentee Vote Boosts Eaton Lead on Scott†

Mayor Thomas M. Eaton, Republican of Long Beach, in the lead over Democratic Congressman Byron N. Scott in the Eighteenth District race, today forged still further ahead when in the counting of absentee ballots he received 105 additional votes to 94 tallied for Scott. The count is expected to be completed late today.

In the standing before the race entered the final swing of the counting of the absentee ballots today, Eaton led the incumbent by 106 votes, having polled in the election a total of 51,732 against Scott's 51,626. In the count today six votes were recorded for Solomon Carr, Progressive from Bellflower.

The ballots are being rapidly canvassed and will be completed late today if the present speed is maintained, according to Deputy County Counsels Beach Vasey and Curtis Smith, who are on hand to pass on any legal questions that may arise during the official tally.

Congressman Scott, with his observers, is attending the count while Eaton is represented by Attorney John F. McCarthy.

Scott supporters said there was strong possibility that the absentee ballots might win for Scott because most of them are from Navy or Marine Corps men, and Scott is an active member of the House naval affairs committee. Eaton's supporters, however, were confident he would retain his lead.

Democratic observers, led by Scott, were making no challenges. But the Republicans challenged 110 ballots on grounds of improper addressing. Most of these were from CCC and SRA camps, and from Washington, D. C.

Vasey ruled that an absentee ballot cannot be counted after it is challenged unless the party who marked it is present to defend it.

The ballot, however, may later be counted by the courts in the event the contest is carried there for determination.

A total of 765 absentee ballots are being tabulated out of a total of 964 returned. Approximately 199 have been challenged and rejected for failure of voters to comply with absentee ballot law requirements.—Los Angeles *Herald,* November 16.

* * *

Long Beach City Election Interests Congressman Scott†

Representative Byron N. Scott in a radio speech last night made the double announcement that the congressional fight in this district is not ended and that the campaign for Long Beach's municipal election next year is starting. He charged that the challenging of absentee voters' ballots in the November 8 election, in which he, the Democratic incumbent and candidate for reëlection, was defeated, on the face of semi-official returns, by Mayor Thomas M. Eaton, Republican, had disfranchised Democratic voters entitled to vote. . . .

Eaton Holds Lead

With the count of absentee ballots, Mayor Eaton had a lead of 288 votes over Representative Scott in the November 8 election. His plurality, with absentee ballots excluded from consideration, was 106. Of the absentee ballots, eighty-two were challenged, sixty-nine by Eaton observers and thirteen by Scott supporters; 122 ballots were rejected by the tabulating officials for improper execution.

Had Scott received all of the challenged votes and all of those rejected by election officials, Eaton still would have had a plurality on the basis of the semi-official count, it has been pointed out.

The official canvass of November 8 votes now is being made by the Board of Supervisors. Probably the incumbent's move for a recount of the Eighteenth Congressional District vote will be made after completion of the official canvass.

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* Correspondence in relation to the symposium should be addressed to the Administrative Office, Symposium on Mental Health, A. A. A. S., Room 822, 50 West Fiftieth Street, New York City, Paul O. Komora, Administrative Secretary.

†This item is of interest because it was Congressman Scott who, in the last session of Congress, introduced the bill to investigate the American Medical Association (CALIFORNIA AND WESTERN MEDICINE, May, 1938, page 306).

Later reports of the absentee vote showed Mayor Eaton to have been elected by several hundred votes.

It will be impossible for a court contest of the Eaton-Scott votes to be launched until after the official canvass will have been certified by Secretary of State Frank C. Jordan.

That was the opinion expressed today by Registrar of Voters W. M. Kerr.

Kerr said that the official canvass in behalf of Los Angeles County will not be certified until November 29.

Long Delay Seen

At least a week will be required before returns can be forwarded to Sacramento and certified by the Secretary of State.

Then the result is open to challenge in the courts.

Under the sequence of events, it would appear that the final outcome of the race more than likely will be delayed until the Christmas holidays.

Registrar Kerr today stated definitely that he will not include 142 rejected absentee votes in his canvass total nor will he include eighty-nine challenged votes.

"The counting of these votes will be a matter for the courts to decide, if there is a contest," Kerr said this morning.

The election contest must be brought within thirty days from the time the totals are certified in Sacramento by the Secretary of State.—Long Beach *Press-Telegram*.

* * *

Los Angeles County Supervisors Seek $100,000 From United States for Health Survey

Steps to obtain $100,000 for a health survey throughout California were taken by the Board of Supervisors when a motion was passed calling on Dr. Walter M. Dickie, state health officer, to appeal to federal authorities for funds under the proposed congressional bill which would set up $850,000,000 for health work throughout the nation.

Supervisor John Anson Ford stated that California and Los Angeles County should be prepared to obtain all possible benefits under the proposed bill, and he expressed the belief that the state would get an excellent start by making a competent survey of all persons afflicted with various diseases in California.

The board's motion suggested that Doctor Dickie make his appeal to the surgeon-general of the United States—Los Angeles *Herald*, November 16.

* * *

Doctor Gibbons Will Head Fair Hospital

Dr. Morton R. Gibbons, Sr., noted surgeon in his own right and fifth in a family of medical men, will be in charge of the hospital to be operated at Treasure Island next year. He inspected the new facilities yesterday.

The hospital, already completed, is housed in the north wing of the Administration Building. The Exposition Hospital, modern in every respect, will be maintained, after the fair closes its doors, as a permanent adjunct of the airport.

Doctor Gibbons is a past president of the California Medical Association and past medical director of the State Industrial Accident Commission.

The hospital probably will be manned by three or four doctors and an equal number of nurses. Exposition officials are not expecting any trouble but "after all it's a city for millions next year and we have to be prepared for anything," one officer said.—San Francisco *Chronicle*, November 4.

* * *

Medical Care Offered Needy Farm Families

Farm Security Administration Operates Programs in Seventeen States

Special to The News

Washington, October 18.—Special medical care programs for low-income farh families are now in operation or in process of preparation in sixteen states besides California, Farm Security Administration said today.

The announcement indicates the extent to which rehabilitation of farm families in their own states is being attempted to prevent further westward migration.

Statewide medical care programs go into effect in North and South Dakota on November 1.

Agreements are Reached

Agreements have been reached with state medical associations in North Carolina, Wisconsin, Utah, New Mexico, and Colorado, and programs are being discussed with local medical authorities.

Farm Security Administration will loan each needy farm family signing up for the North and South Dakota programs a total of $16, or $2 a month for the rest of this fiscal year. The money will be turned over to a special corporation in each state.

Supervisor To Be Named

The corporation will allocate the funds between physicians, dentists, hospitals, pharmacists, and nurses. Families signing up will then be eligible for medical, dental, or hospital care from any members of the professional organization.

In each state an officer nominated by the medical association but paid by the state health department, will serve as general medical supervisor and arbitrator, passing on the bills submitted to prevent excessive charges. — San Francisco *News*, October 21, 1938.

* * *

Health Department Seeks More Power

Doctor Geiger Says Authority Needed to Meet Emergencies

An ordinance to provide the San Francisco Health Department with greater authority in its battle with diseases and epidemics was urged by Director J. C. Geiger today in a letter to City Attorney John J. O'Toole. Doctor Geiger said his department now must rely on a state statute for authority in emergencies.—San Francisco *News*, November 7, 1938.

* * *

San Mateo Health Survey

San Mateo County civic clubs, the County Medical Association and the new Ministerial Association appeared today before the Board of Supervisors to demand that a request for a Federal survey of health conditions be made to the United States Public Health Service.

The demand was a climax to a long fight for the survey, which apparently had ended in September when the supervisors promised to request the survey. They wrote the letter but never mailed it.

Failure to get the letter off resulted in new protests, leading to today's meeting. The Medical Association declared Surgeon General Thomas Parran had wired them assurance of his willingness to order a survey once request had been made formal.—San Francisco *News*, November 1, 1938.

* * *

California Voters To Ballot in 12,472 Precincts

Sacramento, October 22—UP).—California voters will cast their ballots November 8 at 12,472 precincts, an increase of forty-three over the number of voting places at the August 30 primary elections, Secretary of State Frank C. Jordan announced.

The number of precincts in each county follow:

Alameda, 1,273; Alpine, 5; Amador, 25; Butte, 124; Calaveras, 33; Colusa, 28; Contra Costa, 176; Del Norte, 20; Eldorado, 36; Fresno, 252; Glenn, 35; Humboldt, 117; Imperial, 83; Inyo, 30; Kern, 228; Kings, 54; Lake, 32; Lassen, 50; Los Angeles, 4,482; Madera, 42; Marin, 109; Mariposa, 22; Mendocino, 88; Merced, 68; Modoc, 23; Mono, 8; Monterey, 109; Napa, 51; Nevada, 42; Orange, 246; Placer, 64; Plumas, 30; Riverside, 166; Sacramento, 338; San Benito, 29; San Bernardino, 358; San Diego, 483; San Francisco, 1,055; San Joaquin, 233; San Luis Obispo, 79; San Mateo, 240; Santa Barbara, 130; Santa Clara, 294; Santa Cruz, 109; Shasta, 55; Sierra, 16; Siskiyou, 73; Solano, 79; Sonoma, 167; Stanislaus, 121; Sutter, 31; Tehama, 54; Trinity, 26; Tulare, 139; Tuolumne, 34; Ventura, 100; Yolo, 44; Yuba, 34. Total, 12,472.

* * *

Meet to Discuss Humane Pound Act

A public meeting to discuss the State Humane Pound Act, Proposition No. 2 on the November ballot will be held by the California Animal Defense and Antivivisection League next Tuesday, at 8 p. m. in Burdette Hall, Philharmonic Auditorium, according to an announcement made today by the California Citizens' Committee, sponsoring this act.

Guest of honor will be Leo Carillo, motion picture actor who has endorsed the measure.

Rollin McNitt, Los Angeles attorney, will speak on the legal aspects of this initiative measure. Dr. Wolf Adler, prominent physician, will refute the argument, that this measure is an antivivisection bill, it was announced. Other speakers will include Dr. P. M. Lovell and W. I. Clendenon, who will be chairman.

Carillo in endorsing the State Humane Pound Act said, "Look into a dog's eyes and you will find no greater love, faithfulness and sincerity. Give our dumb friends a chance by voting yes on Proposition No. 2."—Los Angeles *Evening Herald-Express*, October 22.

* * *

Prostituting the Initiative!

In several states by constitutional amendment the people have the right to vote directly on legislation which they themselves initiate or on measures already passed by the legislature. By this means the laws of the state may be

made more clearly to reflect the will of a majority of the voters. The initiative procedure, however beneficial its attributes may be theoretically, has unfortunately been utilized by small groups to foster schemes for selfish ends. On November 8 the people of three states will vote on measures initiated by such groups.

In California a measure initiated by a small group of emotionalists seeks to cripple scientific research in the state by making it difficult if not impossible to procure animals for experimental purposes. In Oklahoma an initiative measure proposes, among other things, to permit hospitals legally to enter into contracts for medical services, if the hospital is organized "on a mutual and coöperative nonprofit plan in connection with some recognized farm or labor union or church or charitable organization." In Colorado, initiative amendment No. 2 proposes by constitutional amendment to guarantee to every person in the state the exclusive right to choose his own state license system of healing and physician for state-required examinations or for therapeutic services in connection with state compensation or other insurance benefits and to open the doors of all tax-supported or partially tax-supported corrective, therapeutic or eleemosynary or other public institutions in the state to the cultists. The Colorado amendment, if adopted, will repeal the basic science act enacted by the legislature in 1937, will deprive the legislature of any future right to exercise its police power in protecting the people from the ministrations of incompetent healers and will devolve on any profession recognized by the state the "exclusive right to examine, license and regulate the practice of its own members through its own legally constituted power or authority."

It seems inconceivable that these measures will receive the approval of the voters in these three states. The tragedy lies in the fact that a procedure conceived in the public interest may be invoked and utilized for purposes inimical to that public interest.—*Journal of the American Medical Association*, November 5, 1938.

* * *

His Good Deeds Stand Out

His mortal eyes forever closed, Pasadena today pauses to acknowledge its debt to Dr. Walter P. Bliss. It is a greater debt than it is possible for the general public for the moment justly to appraise. That can be done only by those in individual homes and in hospitals who have been the beneficiaries of his skill and of his kind and encouraging words.

Whatever his weaknesses, a mantle of charity now covers them. Looming out above them and shining clear are good deeds that cannot be, will not be, forgotten by the community.

In the course of his years of practice many and many were the sad souls who turned to Dr. Bliss in their hours of pain and anguish. Their pain and anguish he relieved. His own pain and anguish was more than he could bear. Now he rests, his earthly labors ended and his debts all paid.

Mingled with regrets over the tragic passing of Doctor Bliss are feelings of sympathy for the ones who, until sorrow came into it, made home happy for him, and which he in turn made happy for them.

Doctor Bliss will be remembered gratefully for his noteworthy services to mankind long after his human frailties, no matter what they were, have passed from mind. Editorial Views of the Pasadena *Star-News*, by Charles H. Prisk: Pasadena *Star-News*, November 4.

* * *

Elixir Maker Pleads Guilty

Kansas City, October 19—(AP).—Dr. Samuel E. Massengill, pharmaceutical manufacturer, pleaded guilty to a misdemeanor charge in connection with the transportation of an elixir of sulfanilamide before Federal Judge Merrill E. Otis today and was fined $9,500.

The American Medical Association attributed seventy-three deaths last year to use of the compound.—Los Angeles *Times*, October 20.

* * *

Tulare Loses Federal Office to Visalia

The county office of the recently established Agricultural Workers' Health and Medical Association has been moved from Tulare to Visalia, where it is now located at 1110 East Main Street. It was formerly in the Young building here.

The Agricultural Workers' Health and Medical Association is a government agency to provide medical care for needy transients. It dispenses federal funds, certifying to private physicians and private hospitals sick or injured transients who have not been in California long enough to qualify for county aid. Unfortunately, the bulk of such cases in Tulare County are in the southwestern part of the county, and will now have a trek to Visalia and back to make when seeking aid.—Tulare *Advance Register*, November 4, 1938.

Geiger Warns of Rabies Danger

Dr. J. C. Geiger, San Francisco health officer, today urged police and public coöperation to prevent spread of the San Mateo County rabies epidemic which has claimed eighteen victims of mad dog bites in the past ten days.

"Because most dogs in San Francisco are kept in apartments, danger to humans is greater than in any other area except New York City," Geiger declared.

Meantime, parents of Robert Stentiford, age fourteen, of Menlo Park, who have steadfastly refused to allow the boy's submission to treatment after he was believed to have been bitten by a rabid dog, declined to comment today. All other known victims have been treated.

With San Mateo County and nearby San Jose under rigid surveillance for signs of rabies, Doctor Geiger issued these precautions to San Franciscans:

Permit no contact between your dog and strays; report all stray dogs to the pound; have your veterinary advise concerning prophylaxis; have all dog bites treated within an hour; keep your dog on a leash and if your dog appears ill seek a veterinary's advice.—San Francisco *Call-Bulletin*, October 24.

* * *

Health Insurance Topic

"Health Insurance vs. 'The Free Practice' of Medicine" will be discussed by Dr. Barbara Armstrong, nationally known authority on social insurance and professor of law at the University of California, next Sunday evening when the Haskalah Club holds its November meeting at the Western Women's Building. An open forum will follow.—San Francisco *Call-Bulletin*, November 9, 1938.

* * *

State Medical Men See New Hospital

Dr. William W. Roblee, President, and Dr. George Kress, Secretary, of the California State Medical Society, visited the Butte County infirmary this week. They inspected the buildings and conferred with Dr. L. A. Jacoby, county physician, and Archie Allen, superintendent, Dr. Jacoby said. —Oroville *Mercury Register*, November 4, 1938.

* * *

Camp to Start Own "Hospital"

Salinas, November 8.—As suddenly as it started, the "relief" war between county, state, and federal governments over Camp Ord ended today.

At a meeting of the board of supervisors, representatives of the SRA and WPA—Dr. John C. Sharp, medical and health director for the county, and Welfare Director W. H. Leach—reached a solution to the problem which last week saw the board refuse further aid to the 585 Camp Ord indigents on the ground they were not county residents.

County officers were informed that camp directors will undertake a hospital program of their own, thus relieving the county of the burden of extending aid to injured and sick camp members.

The county, on the other hand, promised to continue aid to forty-eight SRA clients, all county residents, employed at the camp but not a regular part of the WPA project.

In addition, the county hospital will take care of "emergency cases which the Camp Ord hospital staff is unable to handle, either through lack of facilities or otherwise," Chairman Andrew B. Jacobsen said.—San Jose *Mercury-Herald*, November 9, 1938.

LETTERS

Subject: Status of osteopathic licenses.

(COPY)

San Francisco, October 31, 1938.

Ralph H. Cowing, Esq.
Deputy Attorney-General
State Library and Courts Building
Sacramento, California

Re: *Jordt* vs. *California State Board of Education*; No. 58214, Department No. 3.

Dear Mr. Cowing:

I have now had an opportunity fully to examine your letter of October 27 and enclosed copies of briefs presented to the Superior Court by Mr. Brannely, attorney for Jordt, and yourself, as attorney for the State Board of Education.

With respect to the point raised by Mr. Brannely concerning osteopathic physicians and surgeons' licensed by the Board of Medical Examiners between 1917 and 1923, it is my recollection that there are not more than one hundred such physicians in active practice at the present time. (I note, however, that Mr. Brannely states there are three hundred.) These men received physicians and surgeons' certificates from the Board of Medical Examiners between 1917 and 1923 under Section 12½ of the Medical Practice Act then in effect. Under said Section 12½ an osteopath could receive from the Board of Medical Examiners a physicians and surgeons' certificate if (1) he had complied with the *educational requirements* for a physicians and surgeons' certificate and, in addition, successfully passed the examination given by the Board for physicians and surgeons' certificates, or (2) he had practiced osteopathy for at least four years and, in addition, passed the examination for a physicians and surgeons' certificate (the exact requirements appear in Cal. Stats. 1917, page 106, near the bottom of the page). Thus it can readily be seen that osteopaths could not secure a physicians and surgeons' certificate between 1917 and 1923 without satisfying the Board of Medical Examiners that they possessed sufficient educational background to be entitled to practice medicine and surgery.

On the other hand, since 1923 physicians and surgeons' certificates are issued to osteopaths by the Board of Osteopathic Examiners, which was created by the Osteopathic Initiative. Although the Board of Osteopathic Examiners administers the provisions of the Medical Practice Act, it has the sole determination as to whether or not physicians and surgeons' certificates are to be issued to oseopathic applicants. It would seem clear that the Board of Osteopathic Examiners would naturally be more inclined to issue physicians and surgeons' certificates "to graduates of osteopathic schools" if such graduates had sufficient osteopathic training than they would to graduates of medical schools. On the other hand, the Board of Medical Examiners between 1917 and 1923 most probably did not issue physicians and surgeons' certificates to osteopathic applicants unless such applicants were at least equal to average medical school graduates. It seems to me that a very clear distinction can be drawn between the two types of osteopathic physicians and surgeons.

I believe that the difference between educational requirements prior to 1923 and since 1923 and the difference between the Administrative Board conducting examinations can serve as an answer to Mr. Brannely's contention that Section 5.481 of the School Code discriminates between persons within an identical class.

I note that Mr. Brannely disposes of *Hayman* vs. *Galveston,* 273 U. S. 414, and *Newton* vs. *Commissioners,* 282 Pac. 1068, with the statement that "in those states a physician has no statutory or constitutional right to practice his profession in a hospital." Is it not likewise true that in California an osteopathic physician and surgeon has no statutory or constitutional right to practice his profession in a school? With respect to constitutional rights, it is my recollection that in Texas a state constitutional provision granted to osteopaths full power to practice medicine and surgery so that in Texas an osteopathic physician and surgeon, such as Hayman, had a license as broad as a California osteopath holding a physicians and surgeons' certificate issued by the Board of Osteopathic Examiners.

If I can be of any service to you in connection with other points or in further discussion of the above-mentioned points, please drop me a line.

111 Sutter Street.

Very truly yours,
HARTLEY F. PEART.

Subject: Consultations with cultist practitioners.

AMERICAN MEDICAL ASSOCIATION
Chicago, October 14, 1938.

Dr. George H. Kress
Secretary, California Medical Association
San Francisco, California
Dear Doctor Kress:

I am enclosing a copy of a letter received at this office from Mr. ———, a Los Angeles attorney, and a copy of my reply to it.

535 North Dearborn Street.

Very truly yours,
OLIN WEST.

* * *

(COPY)

Los Angeles, October 12, 1938.

American Medical Association
535 North Dearborn
Chicago, Illinois
Gentlemen:

Would you please advise me whether there is anything in the ethics of the medical profession which would prevent a licensed M. D. from employing or being employed by a licensed Doctor of Osteopathy or Doctor of Chiropracty?

Would you also please advise me if there is any canon of professional ethics of the medical profession which would prohibit a partnership being formed between an M. D. and a Doctor of Osteopathy or between an M. D. and a Doctor of Chiropracty?

Thanking you for your courtesy in this matter, I remain

Very truly yours,
(Signed): ————————

* * *

AMERICAN MEDICAL ASSOCIATION
(COPY)

Chicago, October 14, 1938.

Mr. ————
Attorney and Counselor at Law
Los Angeles, California
My dear Sir:

I have before me your letter of October 12, addressed to the American Medical Association.

It is my opinion that it would be highly unethical for a physician to employ an osteopath or a chiropractor in connection with the provision of medical service or to accept employment at the hands of osteopaths or chiropractors.

Your letter is being referred to the Secretary of the California Medical Association.

535 North Dearborn Street.

Very truly yours,
(Signed): OLIN WEST.

———

Subject: Negotiation of settlements with injured persons.

Re: Article in "Medical Record," regarding New York Statute forbidding adjusters to enter hospital within fifteen days after patient sustained injuries.

October 14, 1938.

To the Editor:—In regard to the above article, which was enclosed with your letter of September 29 asking me to obtain a copy of the penal law involved, I have examined the New York Statutes and find that Sections 270b, 270c, and 270d of Cahill's Consolidated Laws of New York make it a misdemeanor for any person to enter a hospital for the purpose of negotiating a settlement or obtaining a general release or statement, written or oral, from any person confined in said hospital as a patient as the consequence of any personal injuries sustained, within fifteen days after the patient received such injuries.

The evident purpose of the New York Statute is to prevent persons from taking advantage of hospital patients

who have suffered severe injury in an accident and are unable to understand what is proposed to them or requested of them.

Office of Hartley F. Peart.

Very truly yours,
HOWARD HASSARD.

Subject: Legal right of a corporation to practice medicine.*

(COPY)

October 5, 1938.

Dr. George H. Kress
Secretary, California Medical Association
San Francisco, California

Re *People* vs. *Pacific Health Corporation.*

The following is a clipping from this morning's San Francisco *Examiner:*

Stay of Judgment for Health Firm.

The State Supreme Court, which recently held the activities of the Pacific Health Corporation were in violation of the Medical Practice Act, yesterday granted a stay of judgment to the health insurance firm pending an appeal of the case to the United States Supreme Court.

The Pacific Health Corporation is evidently going to try to take the case to the United States Supreme Court, and at all events to secure additional time which will be allowed to make the attempt.

Very truly yours,
(Signed): HARTLEY F. PEART.

Subject: Chiropractic Practice Act of California.‡

BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

To the Editor:—Enclosed please find mimeographed copy of decision rendered by San Francisco Superior Judge Van Nostrand on October 6, 1938, which we trust will result in definitely defining the limitations of the practice of chiropractic in this state.

A copy has been forwarded to each District Attorney in the State of California.

Very truly yours,
C. B. PINKHAM, M. D.
Secretary-Treasurer.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

San Francisco Municipal Employees Health Service System: A Review of a Recent California Supreme Court Decision Upholding the Constitutionality of the System

Late in 1936, a proposal to establish a system of health service for San Francisco City Employees was submitted to a referendum vote of municipal employees who declared themselves in favor of a periodic payment health service plan by a large vote. Thereafter, a charter amendment was submitted by the Board of Supervisors to the electorate and upon approval by vote of the people was submitted to the Legislature. On April 14, 1937, the Legislature approved the proposed charter amendment. This charter amendment added Section 172.1 to the charter of the City and County of San Francisco. The main features of Section 172.1 are as follows:

1. A "health service system" for municipal employees is established to be administered by a health service board.

2. All municipal employees, except those exempted because of religious convictions, are included in the system. In addition, the health service board has power to make provisions for inclusion in the system of dependents of municipal employees, retired municipal employees and temporary municipal employees.

3. The health service board by a two-thirds vote of its members has power to adopt a plan for rendering medical care to the members of the system, or for indemnification of the cost of medical care or for obtaining and carrying insurance against such costs.

4. The board is further empowered to make rules and regulations for the transaction of its business, for the granting of exemptions to municipal employees who "are otherwise receiving adequate medical care" and for the admission of members to the system.

5. The charter amendment provides that upon adoption by the health service board of a plan it shall determine the monthly sum to be deducted from wages of members of the system and then certify such sum to the City and County Controller. Thereupon, the Controller is required to deduct said sum from the compensation of members and deposit all deductions with the Treasurer of the City and County to the credit and for the use of the health service system.

6. The power of the health service board to adopt a periodic payment plan for medical care or for indemnification or to obtain insurance against medical costs is specifically restricted in the following particulars: The board cannot restrict the right of members of the system to complete freedom of choice of physician or hospital, provided, only, that the board may require all physicians or hospitals rendering service to abide by its rules and regulations. The board cannot enter into any exclusive contracts for the rendering of medical services. The board must provide that services are to be furnished at uniform rates of compensation and such rates and any contract respecting the rendering of services is subject to review by and requires the approval of the Retirement Board of the City and County of San Francisco.

The foregoing are not all of the provisions of Section 172.1 of the charter, but they do constitute the most important matters governed.

As above stated, the Legislature approved Section 172.1 on April 14, 1937, and immediately thereafter the section went into full force and effect. Subsequently, the municipal employees elected a health service board which organized and commenced to function. After some months of seeming inactivity and after first endeavoring unsuccessfully to obtain approval by the Retirement Board of an exclusive contract (expressly forbidden by the charter amendment), the health service board formulated and submitted to the Retirement Board a plan known as "Plan No. 1." Prior to public presentation of Plan No. 1, the San Francisco County Medical Society had prepared and submitted to the health service board a proposed plan, most of the principles of which were contained in Plan No. 1, as adopted. This plan called for the rendition of medical services to members of the health service system by any physician in San Francisco who agrees to abide by the rules and regulations of the board and who agrees to accept as full compensation for his services his pro rata share of that portion of the funds collected from municipal employees available for payment of medical compensation. Plan No. 1 was submitted to the Retirement Board and approved by it.

After approval by the Retirement Board of Plan No. 1, the health service board then determined upon the sum of $2.50 a month as the monthly deduction from compensation of members of the health service system. Pursuant to the charter amendment, the health service board notified the

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* For full opinion of the Supreme Court of the State of California, see CALIFORNIA AND WESTERN MEDICINE, October, 1938, on page 306.

‡ Full opinion of Judge John J. Van Nostrand appears in this issue, on page 457.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

Controller to deduct $2.50 per month from the compensation of each municipal employee and to deposit with the City Treasurer to the credit and use of the health service system such sums so deducted. The Controller made the first monthly deduction and then refused to deposit the amount deducted with the City Treasurer until directed so to do by a court of competent jurisdiction.

Thereupon, the members of the health service board petitioned the Supreme Court of the State of California for a writ of mandamus directing the City Controller to deposit said monthly deductions with the City Treasurer as required by Section 172.1 of the charter. That petition is entitled *Butterworth* vs. *Boyd*, and was finally decided by the California Supreme Court in September, 1938. The opinion of the Court is printed in full in CALIFORNIA AND WESTERN MEDICINE, October, 1938, pp. 302–306.

The California Supreme Court held that Section 172.1 of the charter was a valid charter amendment not repugnant to the Constitution of the United States or the Constitution of the State of California and therefore, ordered the Controller to comply with the charter and deposit said monthly deductions with the City Treasurer.

Since the opinion has been published in full, we will not review in detail the rules of law announced by the Court. It should, however, be mentioned that the Supreme Court held the health service system to be a "municipal affair" and, therefore, a proper subject of municipal legislation.

It may well be asked what effect the decision may be expected to have with respect to the legal status of various group medicine and health insurance plans, compulsory or voluntary. The only answer that can be made is that the decision in *Butterworth* vs. *Boyd* upholds the validity of a compulsory health insurance plan for municipal employees, at the sole expense of such employees and contained in a city charter. It goes no further. A compulsory scheme involving the use of tax funds would present an entirely different problem. A compulsory plan, blanketing in *all* residents of a community falling in the low income brackets, would likewise present a different problem. The legal status (whatever it may be) of voluntary "closed-staff" group medical plans is in no manner affected by the decision.

SPECIAL ARTICLES

AMERICAN MEDICAL ASSOCIATION CASE MORE THAN CRIMINAL SUIT*

Broad Problem Cited Social Issue Involved May Reach High Court Hearings Resumed

The Department of Justice states it will resume the painstaking fitting together of the evidence on which it expects an extraordinary district grand jury to indict the American Medical Association and the District Medical Society for conspiring to obstruct the Sherman antitrust act by forming unlawful combinations in restraint of trade.

The proceedings, however, are regarded as more than a mere criminal prosecution, whatever its importance. Being prepared in proper legal form for ultimate consideration by the Supreme Court are issues of broad social significance. The misdemeanors alleged to have been committed in the row between American Medical Association and the Group Health Association, which brought the charges, are the peg on which these issues are hung.

CAN DOCTORS GIVE SOLUTION?

Were the juridical-sociologist experts who are directing the grand jury hearings from the council rooms of the New Deal to discard their policy of silence and explain their proceedings they might phrase these issues like this:

Has the problem of preserving or restoring the health of the individual American become so involved with the new and complex structure of the community that the healing art no longer can supply the solution by functioning on the traditional lines to which it is accustomed—and to which its most solidly entrenched organization, the American Medical Association, clings tenaciously?

Must the physician's economic individualism—which the American Medical Association claims it is safeguarding—give way to group practice or to some other system considered adapted to the needs of modern American society?

Should the medical profession be unable or unwilling to make these adjustments, does the Constitution empower any public agency to coerce them directly or indirectly?

PROBLEM CLOSELY STUDIED

A "totalitarian" settlement of such issues, it was pointed out last week, would be made by decree. However, the present grand jury is only one step in a determination which follows the historic American pattern—invoking many minds, many points of view, both lay and professional, from which will be distilled the new law of the land.

Weeks of study by Department of Justice experts preceded the calling of the extraordinary grand jury. The twenty-three engineers, salesmen, and businessmen over whom Foreman W. R. Bell presides daily in the new Police Court Building are the second stage of the inquiry.

Before them last week four special assistants to the Attorney General laid a general outline of the health problem of the United States. Four experts, three of them listed in "Who's Who," discussed the need they had found for some step to modernize the economics of the healing science.

* Excerpts from an article by Dillard Stokes.

CALIFORNIA STATE HUMANE POUND ACT

For purposes of record, this initiative act, as its title was given on the November 8, 1938, ballots, and the argument against its passage, appear below:

2. *Regulation of Pounds. Initiative Measure.* Defines "pounds" and regulates conduct thereof; prescribes duties of poundmasters; prohibits sale, surrender or use of unwanted or unclaimed animals in pounds for scientific, medical, experimental, demonstration or commercial purposes; exempting kennels, buildings or enclosures maintained on own premises by any accredited college, university or any medical research laboratory licensed under State Medical Practice Act, provided cats and dogs therein were bred on the premises or lawfully acquired under provisions of measure; directs that unclaimed and stray animals for which no bona fide home is available be put to death by an approved humane method.

ARGUMENT AGAINST INITIATIVE PROPOSITION NO. 2

What purports to be a simple humanitarian measure, but what is actually *antivivisection* legislation designed to throttle medical research into the causes and cures of disease, appears on the ballot under the misleading title of "State Humane Pound" act.

Having attempted long and unsuccessfully to pass antivivisection laws before the California Legislature, the antivivisectionists now appeal to the voters for the first time since 1922, when they were defeated by the overwhelming majority of 288,444 votes.

Convinced that the public cannot be stampeded into approving of antivivisection through any straight-forward presentation, the antivivisectionists now choose indirect means of accomplishing their purpose. This is their newest strategy, admitted in their own publications. They have chosen the dog "because the dog appeals to everyone." It is an entering wedge for similar laws everywhere.

Stray animals are weighed against babies by the antivivisectionists. Under the "Humane Pound" act the babies would lose!

Careful analysis by eminent lawyers discloses many "jokers" in the apparently innocuous "Humane Pound" act. The broad definition of "pound, publicly or privately conducted," makes everyone a "poundmaster" who accumulates dogs or cats for disposal, other than for sale as pets.

Animals for experimental or demonstration use would have to be bred en masse on the very premises of the medical institutions, an entirely impracticable procedure. "Domestic animals" are not defined, nor is an "approved method" of destroying them. The way is opened wide for persecution through constant inquisition.

Section 10, in particular, besides being ambiguous, is so all-inclusive as entirely to prevent scientific research involving the use of animals and thus cripple innumerable life-saving activities in California.

Untold benefits have come through animal experimentation. It is responsible for Lister's development of antiseptic surgery. Without it there would be no present-day control of diphtheria, smallpox, syphilis, and diabetes, to name but a few diseases which once scourged mankind. Advances constantly being made in protecting the public health, testing of life-giving serums, standardization of drugs, safeguarding of canned and other foods, and the evaluation of an adequate diet—all would suffer a severe set-back if this legislation were to pass.

The act would handicap California manufacture of serums for treatment of anthrax, blackleg, Bang's disease, and other ailments of cattle; brain disease and tetanus in horses; distemper, blacktongue, "yellows," and nutritional disorders in dogs; hog cholera and other diseases of swine; anthrax, doby mouth, and other ills of sheep, and innumerable diseases of poultry such as pox, cholera, coccidiosis, and flukes.

The mis-named "Humane Pound" act is an intelligence test for the people of California. Foremost educators, professional and lay men and women, and scores of scientific societies urge its defeat. Any doubt that it is an antivivisection measure is dispelled by the fact that the officers of the "California Citizens Committee for State Humane Pound Legislation" and those of the "California State Antivivisection Society" are one and the same!

Vote against the "Humane Pound" proposal. If you do not kill this measure it may kill you.

RUFUS B. VON KLEINSMID,
President, University of Southern California.
RAY LYMAN WILBUR,
President, Stanford University.
P. K. GILMAN, M.D.,
San Francisco.

THE NATIONAL CANCER INSTITUTE ACT*

The anticancer movement in all its converging trends—toward education of the public and of physicians, toward improvement and expansion of clinical cancer service, and toward continuous research—resulted last August in the passage by the Congress of the National Cancer Institute Act upon the provisions of which I shall make some explanatory remarks and comments. The character of the act and the circumstances of its passage are, I believe, unique and illustrate how well prepared the ground is for well considered anticancer legislative action. The purpose of the act is to provide for and to foster the continuous study of the cause, the prevention, the diagnosis and treatment of cancer. "With a view to the development and prompt use of the most effective methods of prevention, diagnosis and treatment of cancer there is hereby established in the Public Health Service a division, which shall be known as the National Cancer Institute." In every provision of the act it is stated clearly that the purpose is to further the study of the causes of cancer and the application of useful knowledge, old and new, to the prevention, diagnosis and treatment of cancer. In other words, the act provides for cancer research, clinical and experimental, as well as for the advancement of clinical cancer service. In support of this comment I read practically without change Section 2 of the Act:

The Surgeon General of the Public Health Service is directed, in coöperation with the National Advisory Cancer Council:

(*a*) To conduct, assist, and foster researches, investigations, experiments, and studies relating to the cause, prevention, and methods of diagnosis and treatment of cancer;

(*b*) To promote the coördination of researches conducted by the National Cancer Institute and similar researches conducted by other agencies, organiaztions, and individuals;

(*c*) To procure, use, and lend radium as hereinafter provided;

(*d*) To provide training and instruction in technical matters relating to the diagnosis and treatment of cancer;

(*e*) To provide fellowships from funds appropriated or donated for such purpose;

(*f*) To secure for the Institute consultation services and advice of cancer experts from the United States and abroad, and to coöperate with state health agencies in the prevention, control, and eradication of cancer.

At this point a brief explanation of the National Advisory Cancer Council is in order: The purpose of this Council, which is an appointed body of six members with the Surgean General as chairman, is to make recommendations to the Surgeon General with respect to carrying out the provisions of the act. Specifically, the Council is authorized to make recommendations in regard to cancer research projects submitted to it or initiated by it; to spread information about cancer studies "for the benefit of health agencies and organizations, physicians, or any other scientists, and for the information of the general public;" and "to review applications from any university, hospital, laboratory, or other institution, whether public or private, or from individuals, for grants-in-aid for research projects relating to cancer, and certify approval of projects deemed worthy of support."

The act provides $750,000 for the building and equipment of the National Cancer Institute. This building will be ready for use in the latter half of 1939. It will be erected at Bethesda, Maryland, on ground donated by Mr. and Mrs. Luke I. Wilson, and where the new buildings of the National Institute are in process of construction. For the fiscal year ending June 30, 1938, $400,000 was appropriated for the Cancer Institute, "of which $200,000 shall be available for the purchase of radium." For the present fiscal year (1938-1939) $400,000 has been appropriated for carrying out the purposes of the act, without any specific restrictions.

On the basis of this statement of the provisions of the act I shall not discuss briefly the steps taken to carry them into effect.

First, radium. As stated $200,000 was available for radium during the past fiscal year. The act itself authorizes the purchase of radium from time to time and that it be available for carrying out its purposes; further that "for such consideration and subject to such conditions" as shall be prescribed, radium may be loaned to institutions in the United States "for the study of the cause, prevention, or methods of diagnosis or treatment of cancer, or for the treatment of cancer." While the complicated and difficult details connected with the distribution by loan of large quantities of radium have not yet been settled fully, actual purchase has been made and arrangements for loans are underway in coöperation with state health departments.

Second, training in technical matters relating to the diagnosis and treatment of cancer. Obviously the framers of the act were impressed with the needs of special cancer training because facilities may be provided for such training to proper persons and such persons or trainees may receive a per diem allowance not to exceed $10 while in training. The existing facilities for systematic postgraduate training in clinical cancer work are inadequate but can be increased without much difficulty. A small number of acceptable cancer centers are prepared to accept trainees and a number of

* By Ludvig Hektoen, M. D., Executive Director, National Advisory Cancer Council.

active and tentative appointments have been made. A graduate of an approved medical school, who has completed a year's internship in an approved hospital and who is not over forty years of age, may be eligible for training provided he intends to devote himself to the clinical diagnosis and treatment of cancer and can furnish reasonable assurances that opportunities for such work will be available when he finishes his training. As a rule stipends for training will not be awarded for continuation of the applicant in the position he is holding at the time he makes his application. Only in exceptional cases will training be provided for a period of less than a year. In most cases at least two to three years of training are necessarily contingent upon the applicant being personally acceptable to the approved institution where training is to be received.

Third, fellowships in cancer research. The act authorizes research fellowships "with such stipends or allowances" as may be deemed "necessary to procure the assistance of the most brilliant and promising fellows from the United States or abroad." There can be no question but that fellowships with reasonable stipends are highly important in developing first-rate men to study cancer, which is the great need of cancer research at this time. With this objective in mind several fellows have been appointed for work on various phases of experimental and human cancer—biochemistry, carcinogenesis, genetics, pulmonary cancer, pathology. It is recognized that appointees should be first-rate men and women with promises of productive scholarship and careers of significance. The possible fate of every candidate for fellowship must be considered with special care.

Actions by the National Advisory Cancer Council. When the Cancer Act went into effect the cancer research in progress in the National Institute of Health and at Harvard Medical College under the auspices of the Public Health Service was transferred to the National Cancer Institute which was placed under the direction of Dr. Carl Voegtlin. The Council has considered and approved this general program and also additional projects dealing with pulmonary cancer and with cancer statistics and incidence. The study of the incidence of cancer in different places is yielding significant results.

The Council is charged with the duty of passing upon applications for grants-in-aid for research projects relating to cancer. So far the Council has considered seventy-seven applications, of which sixteen have been approved; amount $125,002.50.

The largest project of research as well as clinical nature to engage the consideration of the Council so far concerns the establishment of a cancer unit in the Marine Hospital at Baltimore. The regular beneficiaries of the Public Health Service east of the Mississippi River, the medical care of which falls upon the Service, number approximately 170,000. Of these some 40,000 are in the cancer age and consequently some 4,000 cases of cancer will require treatment in the course of the next twenty-five to thirty years. After thorough consideration the Council approved in principle plans for a complete cancer unit with clinical, research and teaching functions.

The Cancer Act directs that there shall be "coöperation with state health agencies in the prevention, control, and eradication of cancer," and steps have been taken to carry that provision into effect.

July 30, 1938.

CALIFORNIA MEDICAL ASSOCIATION MEDICAL SERVICE PLAN*

The California Medical Association's announcement of November 14, 1938, as authorized by the Council at its meeting of October 12, is as follows:

Dr. W. W. Roblee, of Riverside, President of the California Medical Association, with a membership of 6,000 physicians, made an important and interesting announcement today.

"The Council of the Association," said Doctor Roblee, "at its meeting in San Francisco today, directed its Committee on Medical Service to put into final form a plan by which medical and hospital service will be furnished to citizens of California and their dependents on a monthly payment basis.

"The plan will be operated by the California Medical Association or its representatives and will provide the services of all licensed doctors of medicine in the State who are willing to abide by the rules and regulations necessary to operate the plan.

"The subscribers will have free choice of physicians in this group and also of hospitals for it is contemplated to use the facilities of the three large hospital service associations which have pioneered hospital service plans in California, Insurance Association of Approved Hospitals in the Bay Region, the Intercoast Hospitalization Insurance Association in the Sacramento Valley and the Associated Hospital Service of Southern California in Los Angeles and other southern counties.

"The Council has called a special meeting of the House of Delegates of the Association to meet in Los Angeles on December 17 to approve the final plans which will speedily be put into operation after their approval."

* * *

Press clippings concerning the announcement follow:

City Health Service Based on State Plan

California Association Prepares Details of Medical Insurance Program

San Francisco's Health Service System, with six successful weeks behind it, has been much of the inspiration of the state-wide plans now being formulated by the California Medical Association, it was revealed here today.

"The suggestions offered by the Medical Association are basically identified to our plan," Jesse B. Cameron, Secretary of the Health Service Board, said.

"The proposed rules of the medical society have agreed to give power, as we have, to a medical director with rules and regulations for the benefit of the system," Mr. Cameron said.

A warning against permitting history to repeat the experience of the state compensation was sounded by the health service secretary.

"A good law was neglected by the physicians. They held back and neglected to interest themselves so the state and private insurance covered the patient. Thus the patient failed to get the choice of his own physician. Under our plan that privilege is granted," Mr. Cameron said.

Meanwhile, the state association's committee on medical service wrestled with preparation of the state-wide health insurance program for submission to the Association's House of Delegates December 17.

Dr. Karl L. Schaupp, President of the Association's Executive Council, said a list of volunteer doctors would be drawn up and that subscribers to the plan would have their choice from this list. No doctor, he added, will be required to take more patients than he can serve efficiently.

"We shall have to formulate some basic scale of pay for these practitioners," Doctor Schaupp continued. "There are also the problems of fixing a monthly charge for complete medical and hospital care and an additional fee for dependents."

Doctor Schaupp denied the Association was forced to take the step by the threat of "socialized medicine" by the Federal Government.

Formulation of the statewide plan is in the hands of Drs. Charles Dukes of Oakland, T. Henshaw Kelly of San Francisco, and Lowell Goin of Los Angeles, assisted by Howard Hassard and Hartley F. Peart of the Association's legal staff.—San Francisco *News*, November 15, 1938.

* * *

Cutting Medical Costs

Threatened with medical regimentation by the Federal Government the California Medical Association is proposing a form of socialized medicine to be set up by the doctors themselves. It would be similar in some respects to the hospitalization insurance being taken out by many citizens on a small monthly fee basis.

The proposed plan is to be presented to the House of Delegates of the State Association at a meeting in Los Angeles next month. It was explained to Sacramento medical men last night.

* See also editorial comment on page 425; and official and other notices in California Medical Association department, on pages 472 and 478.

Under the plan medical and hospital service will be furnished to Californians and their dependents on a small monthly payment basis. They can select any physician they choose from a list of those who have agreed to abide by the rules and regulations. Existing hospital insurance plans will be merged into the medical service arrangement thereby making one small monthly fee apply to both.

The government's threat to regiment medicine is more than a mere gesture as the doctors well know. In order to prevent themselves being placed under Federal control the California medical practitioners are seeking to establish a system that will provide proper health care for people of moderate income without it continuing a burden on the patient and his family.

Any congressional act placing the care of the sick under Federal regulation will supersede any private plans by the California medicos. However, if the monthly medical protection scheme succeeds it may cause Congress to back down and keep hands off the medical profession.

It would seem preferable to keep medical treatment out of politics, for many reasons. But this treatment must be placed within the reach of all and must no longer be a burden on those of limited income. If the medical men can solve the problem themselves, to the complete satisfaction of the public, they may avoid Federal regimentation. If not they must expect it and will have to comply with whatever regulations the government may set up.

The threat of Federal control, the voluntary step taken by the doctors to place medical treatment within the reach of those of low income and low-cost hospitalization all mean that more widespread health protections are at hand and that rich and poor alike will benefit from them.— Sacramento *Union*, November 16, 1938.

* * *

Low Cost Medical Care

The California Medical Association wisely anticipates the growing demand for low cost health insurance and medical and hospital service.

It is formulating a plan to be presented to its members next month for a vote. There is little doubt that the vote will be in favor of the plan, if the plan is practical and meets with the need of both physicians and patients for a system of medical care as free as possible from regimentation.

The California Medical Association has already recognized formally the need for some system that will give to a greater number of people the benefits of modern medical methods and hospital care.

This need has been apparent for many years.

It was recognized by the National Committee on Medical Care and Costs, headed by President Ray Lyman Wilbur of Stanford.

In the last few years the public demand for such a system has been growing, and now it is plain that if the medical profession does not act voluntarily to meet that demand, it risks the imposition of some bureaucratic system of medical and hospital insurance by the government.—Oakland *Post-Enquirer*, November 16, 1938.

* * *

A Constructive Movement

In initiating a movement intended to develop a statewide health insurance plan, the California Medical Association Sunday took a constructive step forward. Any plan that has for its purpose the protection of any considerable portion of the people against the time of ill-health, if pitched on a sound economical basis, will be welcomed as a service to humanity.

Whether the doctors of medicine have in mind beating the government to it doesn't matter. But if that is the motive lurking back of the proposal, well and good. It is much better that any plan to provide health insurance should come from private individuals as a result of individual effort than it is that the taxpayers, through political appointees, foot the bills. With the enterprise in the Medical Association's hands it will be intelligently and efficiently managed—a boon to those directly concerned.

Any plan the Association works out and gives its approval to is by far to be preferred to one a politically minded group arranges and operates.—Alameda *Times-Star*, November 15, 1938.

* * *

Insurance—Health Plan Expanding

Comprehensive health insurance has been planned for some time by the Insurance Association of Approved Hospitals, Dr. W. E. Mitchell, the association's president, said yesterday.

Mitchell, speaking in support of the plans for medical care insurance approved by the Council of the California Medical Association, reviewed groundwork already established in nine counties, with a participating list of thirty-nine hospitals and a membership of 22,000 members.

Details for the California Association's procedure have not yet been announced, but it is understood the policy will be similar to that of the Insurance Association, whose members receive services and have the costs paid by the common fund.

"There has never been any question but that meeting the cost of illness is difficult for certain income groups," Doctor Mitchell said. "One factor contributing to this has been the large amount of free and part-pay work done in and by hospitals of the metropolitan area.

"It was this condition which caused us to organize the Insurance Association, so that costs of illness might be distributed among those rightfully obligated and at the same time allow everyone to preserve his self-respect by independence of charity.

"What we have been able to do already will be amplified many times over under the combined service now planned. Subject to the California Medical Association's House of Delegates' action, our association will be representative of the new service, a function which we are now ready to perform."—San Francisco *Chronicle*, November 16, 1938.

* * *

Health Plan Gets Flood of Applications

The City Employees' Health Service System was receiving a flood of applications for membership yesterday on behalf of dependents of employee members.

Beginning next Tuesday dependents will be accepted only after physical examinations. This will rule out, for those applying after that date, correction of chronic or pre-existing ailments at the expense of the insurance system.

A report from the medical department of the system yesterday indicated a surplus from the first month's operation of between $1,500 and $2,000, according to Jesse B. Cameron, secretary.

The system's receipts were $23,234 from 9,293 employee members, $2,375 from 950 adult dependents, and $608 from 518 minor dependents, or a total of $26,217. Expenses of the medical department were $13,661 for 329 doctors, $4,287 for hospitals, $1,182 for x-ray laboratories, and $524 for clinical laboratories, a total of $19,656. Administration expenses had not been fully computed.

Of the 10,761 members, 1,364 were given medical service during the month. About one hundred operations were performed. Physicians who took a chance under a unit system of receiving only part of their fees, were being paid in full.

Membership, with certain exceptions, is compulsory for city employees, from whose pay checks $2.50 per month is deducted. Membership for dependents is optional. The adult dependent payment is the same as for employees. Children obtain membership for $1.50 per month where there is but one in a family; at $1 each where there are more than one. —San Francisco *Chronicle*, November 11, 1938.

* * *

Doctors Stimulated

President Roosevelt's announced intention of establishing a nationwide, low-cost group health service has proved to be a "shot-in-the-arm" for California's medical fraternity.

The California Medical Association, long opposed to group health service on any but a private basis, and sometimes aggressively inimical even to private associations providing it, will decide next month whether to accept or reject recommendations of its medical service committee that a comprehensive system be established.

Indications are the recommendations will be accepted because they are backed by several of the leading physicians of the state.

The plan contemplates a system to be operated by the Association. It will provide participation by all licensed doctors who are willing to abide by the rules. Citizens may obtain the service by paying a nominal monthly fee and will have free choice of physicians from the accredited list. Facilities controlled by the three large hospital service associations of the state will be available.

Now that they have embraced the idea some of the doctors express the hope that the California plan will be a model for the national system President Roosevelt proposes. Some others, a bit franker, say they hope to beat the National Government to the punch in order to avoid having a Federal system imposed upon California. That is another way of saying they hope to avoid "state medicine" in California, "state medicine" being a term that makes a majority of practitioners shudder.

No matter what produced the sudden determination of the Association to launch its project the decision should be hailed with gratification by all Californians.

For too many years the public has waited patiently for relief from the high and frequently prohibitive costs of medical care.

Let us hope no hitch will prevent final approval and early establishment of the proposed plan in this state.—San Francisco *News*, November 15, 1938.

Medical Aid Plan Will Be Discussed in City Tomorrow

State Association Proposes Socialized Monthly Program

The California Medical Association's tentative proposal to establish a medical insurance plan for Californians will be discussed here tomorrow night when Dr. W. W. Roblee of Riverside and Dr. George Kress of San Francisco, president and secretary, respectively, of the Association, pay their annual visit.

Dr. Frederick N. Scatena, Sacramento district counselor of the organization, said the Association Council, meeting in San Francisco on Saturday, authorized its medical service committee to draft into final form a plan to provide medical service on a monthly payment basis, supplying free choice of hospitals and physicians.

Three Groups Would Be Used

The plan contemplates utilizing the facilities of three large pioneer hospital service associations, the Intercoast Hospitalization Insurance Association in Superior California, the Insurance Association of Approved Hospitals in the San Francisco Bay area, and the Associated Hospital Service of Southern California.

"The plan would be operated by the California Medical Association or its representatives and would provide the services of all licensed doctors of medicine in the state who are willing to abide by the rules and regulations necessary to operate the plan," Doctor Roblee stated.

Delegates Will Vote

The medical association's House of Delegates will vote at a special meeting in Los Angeles on December 17 on whether it will adopt the program.

The meeting here tomorrow night will be in the Sutter Hospital. Dr. Dave F. Dozier, president of the local body, will preside.—Sacramento *Bee*, November 14, 1938.

SOCIALIZED MEDICINE

National debate over the proposal to socialize medicine has brought to the fore another angle of the discussion few who criticize the medical profession pause to consider. If we are honest with ourselves we must admit it is doubtful whether more doctoring is as badly needed as is some device to persuade the common or garden variety of patient to do what the doctor tells him.

As a matter of fact, most of us think we know more about ourselves than the doctor possibly can. At least, if we do not think so, we give a letter-perfect imitation of thinking so. To this fact is due a great deal of the enormous cost for medical attention in the United States which is the fundamental basis from which those who would socialize medicine bring their argument.

Frankly, the nation needs socialized medicine much less than common sense. If patients had more of that commodity, and realized the folly of seeing a physician and then stubbornly refusing to follow his instructions, there would be less serious illness and fewer premature departures from this vale of tears by persons who are really ill but knew entirely too much to follow their doctor's advice.

WE PAY LITTLE ATTENTION

The manifest folly of hiring a dog and doing one's own barking ought to require no argument.

It is not that we remain away from the doctor, of course, because we rush to him, most of us, at the first twinge of pain. We suffer his prods and the various tests he makes, and answer his various questions as truthfully as possible, maybe, provide whatever he wishes for laboratory purposes, then fearfully await his verdict.

And when we get that advice, we pay little attention to it.

Perhaps we are told our appendix should be removed. But we ignore the advice either because there is no pain in that region or what pain there was has disappeared. Or we hear that a strict diet is indicated because of high blood pressure. Perhaps the examination has disclosed a bad heart, with a condition of sufficient gravity to cause the doctor to prescribe a month or two in bed.

Having had the examination and received the verdict, and the advice, what do we do about it? The fact is we usually do nothing about it. We decide the doctor knows nothing about it anyway. Or we figure a modified form of the regimen he prescribed ought to do the trick. We stick to the diet for two days, perhaps, then fall off with a bump.

SAME OLD QUESTION

If the month or two in bed was indicated, we ask ourselves and anybody who will listen, how in the name of heaven can we spend a month or two in bed and earn a living at the same time? So presently we delight our heirs by dropping off and the living we had to make all at once becomes of no importance.

A further elaboration of this theme would be merely redundant.

We all know we are too self-willed and impatient and lazy to follow a doctor's directions. We all know that coöperation and obedience are the rarest virtues known to mankind. Until we Americans, rich and poor, agree to coöperate with our medical adviser and obey his decrees, discussion of bigger and better medical attention is just so much piffle.—*San Bernardino Telegram*, October 7.

WASHINGTON MERRY-GO-ROUND

Government Group Health

While the battle between "Group Health" and the American Medical Association flares in District of Columbia courts, it is not generally realized that the New Deal has established, and in most cases subsidizes, group health units in twenty-five states.

Farm Security Administration—heir to Tugwell's Resettlement—is the parent of these units, with the purpose of keeping farmers in health so they can work out of the debts they owe FSA.

Government Group Health also had to fight the American Medical Association, and thrived on the opposition. The idea is spreading so widely that it amounts to a lot more than an expedient for FSA to get its money back. It is fast becoming a nation-wide practice.

In South Dakota, for example, one-half of all the farm families of the state are eligible for group health treatment. Member families pay a regular fee—sick or well—of $2 a month, and the doctor takes care of them for anything from a toothache to child-bearing.

Doctors have to forego fancy fees, but they are glad to have the business. Here are some sample fees paid by group health units:

For extracting a tooth, $1.50; for a doctor's house call within town limits, $2; for an office call, $1.40; for hospital ward service, $2.50 per day; for complete obstetrical examination before childbirth, $3.40; for childbirth, $20. The maximum charge for a major operation is $50, the minimum $15.

Where members of a group health unit cannot pay their $2 monthly fee, the Government lends them the money. On these loans, made in the past, about 80 per cent is paid back. The balance represents a direct Federal subsidy.

Though the American Medical Association has fought the group health plan, state medical associations affiliated with American Medical Association are working with Farm Security in every state where the units have been established.—San Francisco *Chronicle*, October 24, 1938.

CAPITAL DOCTORS BACK SOCIALIZED MEDICAL PLAN

Leaders Warn Action Must Be Taken To Block State Action

The Sacramento Society for Medical Improvement last night unanimously endorsed and pledged its support to the California Medical Association's proposal to offer Californians joint medical and hospitalization insurance.

More than fifty of Sacramento's leaders in medicine were present in the Sutter Hospital auditorium to hear Dr. W. W. Roblee of Riverside, President of the California

Medical Association, and Dr. George Kress of San Francisco, secretary of the association, explain the plan which the state organization is drafting into final form to be voted upon by the physician delegates at a convention in Los Angeles December 17.

WOULD BLOCK FEDERAL ACTION

Both officials warned that unless such a program is adopted, legislation, both State and Federal, which would put into effect some form of socialized medicine, is imminent.

"The heat is on from many sources for some type of medical insurance for the great middle class of our State," declared Doctor Roblee. "We have heard frequent warnings from Washington and from the President. We know from past statements, both by the governor elect and the lieutenant governor elect, that they are going to insist upon some form of adequate medical care—social medicine, if you please—during their terms in office.

"We are unalterably opposed to compulsory medical insurance. We know it would not work here. Neither would socialized medicine. We must put forward an intelligent, workable plan of our own and forestall forced adverse action by nonmedical men."

MONTHLY COSTS

Doctor Kress intimated that the cost of the Association's insurance probably will be about $2.50 a month. He stated that 500,000 persons in California might take advantage of the plan. He also warned against the enactment of compulsory medical care insurance.

"If our plan will prevent the enactment of adverse legislation or the enactment of a compulsory insurance law that would change the whole picture of medical practice in California, we will not have failed," he said.

"If we are to be regimented into a program in which dull mediocrity is the rule, the service we would give would be far below the excellent standards we give gladly and freely today."

COMPLETING ANNUAL TOUR

Doctors Roblee and Kress are completing an annual tour of Superior California medical associations. Dr. Dave F. Dozier, president of the local association, presided at last night's meeting.—The Sacramento *Bee*, November 16.

UNITED STATES TO KEEP SECRET NAMES OF WITNESSES AGAINST AMERICAN MEDICAL ASSOCIATION*

Justice department attorneys handling the extraordinary grand jury investigation of the fight by "organized medicine" against the group health movement decided to try to keep secret the names of witnesses to be called before the grand jury.

The inquiry will reconvene, with jurors listening to witnesses whose identity will not be revealed now, if at all. The purpose in refusing to make public in advance names of witnesses, it was explained, is to conform to Justice Proctor's admonition to keep proceedings secret.

The department, however, it is understood, intends to spend the first three or four days in calling witnesses who will give the "background" of the group health controversy, particularly from the standpoint of complaints that the American Medical Association and local medical organizations have tried to suppress the movement.

GROUP HEALTH ASSOCIATION CHARGES LATER

Not until then will the grand jury hear that part of the story which relates to charges that the District Medical Society, with the help of the American Medical Association, has endeavored to break up Group Health Association, Inc., local organization formed by Government workers in the executive establishment for the purpose of spreading medical costs.

The investigation relates entirely to the district situation, and it is on this basis that indictments will be sought for violation of the Clayton antitrust act, both against leaders of the District Medical Society and the American Medical Association.

MAYO SURGEON WITNESS

The background testimony, designed to give the general picture for the entire country, opened yesterday with appearance before the grand jury of Dr. Hugh Cabot, Mayo Clinic surgeon and a savage critic of the American Medical Association. It is understood Doctor Cabot described the organization of the national medical group.

Doctor Cabot, as well as witnesses who will follow him in laying the groundwork for the narrative relating to the district, are appearing voluntarily. Other witnesses will be subpenaed. Doctor Cabot concluded his testimony at the afternoon session.

Doctor Cabot's appearance launched a prosecution which —if the organizations are indicted—is due to lay squarely before the Supreme Court the long disputed problems of "socialized medicine" and Government control of the healing science.

TO FIGHT TO THE LAST

The American Medical Association has challenged the Government to take it to court and promised to resist to the utmost efforts to brand it as a monopoly.

Doctor Cabot has charged that private practice in this country is not able to safeguard the health of the people and has championed group efforts to place medical treatment within reach of the people generally. The American Medical Association opposition to such movements he calls "medieval."

* Excerpts from a press article by Dillard Stokes.

AMERICAN MEDICAL ASSOCIATION APPROVES UNITED STATES PLAN FOR SWEEPING HEALTH PROGRAM

Washington, November 1—(UP).—Government health officials began drafting today details of an $850,000,000 a year national health program after reaching agreement in principle with the American Medical Association.

Prominent doctors and medical economists returned home after a seven-hour conference which placed four out of five of the Government's major proposals in a state where "plans for action may now be formulated," officials said.

The program calls for:

1. A $200,000,000 expansion of preventive public health services and broadening of the social security act to increase provisions for maternal and child care.
2. A hospital expansion program to increase the facilities available for medical care.
3. Extension of medical assistance now available to low income families.
4. Development of a plan of insurance against loss of wages during sickness.

These points were part of a broad health improvement plan advanced by President Roosevelt's special interdepartmental committee on coördination of health and welfare activities at the national health conference last July. The American Medical Association later approved them in substance.

The program would be organized on a ten-year basis. Economists estimated that $850,000,000 would be the peak annual expenditure during that period.

On one point the conference yesterday failed to reach agreement—establishment of compulsory health insurance under Government supervision. The American Medical Association rejected that plan at the meeting of its House of Delegates in Chicago several weeks ago and yesterday's conference apparently brought the two groups no closer together on that issue.—San Francisco *Chronicle*, November 2, 1938.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XI, No. 12, December, 1913

From Some Editorial Notes:

The Second Decade.—This issue of your Journal completes the first volume of the second row of ten and is sturdier by far than its elder brother of ten years ago. Before discussing anything else, the editor (late Dr. Philip Mills Jones) desires to express his sincere thanks to all those who have helped to make up this last volume and for the almost perfect courtesy and consideration which have been extended to him and to the Publication Committee, alike by those whose contributions have and have not been accepted. Two things are to be distinctly noted as indicating advancement: first, the quality of the papers written by our physicians in California has improved very markedly in the last ten years, not alone in the matter presented but also in the care displayed in writing and the preparation of manuscripts; second, the circulation of the Journal is slowly but surely increasing in spreading through the country, and this in spite of the fact that no agents are employed and no "sample copies" have been sent out. . . . Of course, the Journal and its Publication Committee and its editor have been criticized; it would be impossible to be otherwise; it would be impossible to print a single issue that would entirely satisfy every one of the three thousand readers. Questions arise that are matters of the gravest policy, and in determining a line of action, personal considerations must be ignored, and so some persons' feelings are apt to be hurt. But while that is to be regretted, it cannot be helped unless the character of the Journal is to be entirely changed and it is to become a spineless thing, repeating only pleasant words and expressing no definite attitude on any vexed question, and your editor believes that the vast majority of our members to not desire such a change. . . .

* * *

Ye Humours of Ye Blood.—We travel quite a lot in circles, we human animals; not so much is it "the swing of the pendulum," of which we hear a great deal, as a real circular movement. Years ago, every abnormal condition was due to some humor of the blood; the blood was too thick, or too thin, or was bad; "bad" was a very broad and catholic word. Then came a time when all that "humor" business was laughed to scorn and the blood was never at fault; always there was some specific or other thing to be reckoned with and fought to a finish; the blood was a fluid stream that remained always the same. But see how we have changed in these last few years! . . .

* * *

Our Critics.—There appears to be a disposition on the part of the "many headed" to bewail the quality, or rather the lack thereof, of our editorial comment. . . . Our critics would have us eschew politics or reference to the actions of politicians, even when these bear directly upon matters medical. They weary alike of "fulminations against vendors of proprietary nostrums" and "impersonal diatribes directed at illegal practitioners." . . . They profess Wagner, but their ear is attuned to ragtime. They do not wish to be instructed. They dread to be exhorted. They would be amused. But that is really a large undertaking. Said Garrick, "I am always ready for tragedy at any hour of the day or night. But comedy! Ah, that is a serious matter!" Reflection would seem to show that our critics have collectively debarred us from discussing about everything except personalities. To be sure, personalities are always entertaining—at least, to those who are, to use a slang expres-

(Continued in Front Advertising Section, Page 16)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

Board Proceedings

At a regular meeting of the Board of Medical Examiners held in Sacramento, California, October 17 to 20, inclusive, over sixty applicants wrote the examination, including physicians and surgeons, drugless practitioners, and chiropodists.

The following changes were made in the status of licentiates:

Frank A. Pearl, M.D., license revoked on March 10, 1938, was restored on October 17, 1938, and he was placed on probation for a period of five years.

Benjamin Belove, M.D., charged with aiding and abetting, was on October 20, 1938, found guilty and placed on probation for a period of three years.

James Rossward Carr, licensed chiropodist, charged with the use of a fictitious name, was on October 18, 1938, placed on probation for a period of three years.

Clarence Carleton Chappelle, M.D., charged with alleged illegal operation, was on October 18, 1938, found guilty and his license to practice in this State was revoked.

Ralph Culbertson Cloninger, M.D., charged with alleged illegal operation, was on October 20, 1938, found guilty and he was placed on probation for a period of five years, with the further penalty that he shall not practice prior to January 1, 1939.

Henry L. Gardner, M.D., charged with aiding and abetting, was on October 20, 1938, found guilty and he was placed on probation for a period of three years.

Abraham Gottlieb, M.D., was on October 20, 1938, found guilty and placed on probation for three years.

Leo L. Kafka, licensed chiropodist, charged with aiding and abetting, was on October 19, 1938, found guilty and placed on probation for a period of three years.

Morris Philip Kaufman, M.D., charged with alleged addiction, was on October 20, 1938, found guilty and his license to practice was revoked.

William Raymond McDannell, M.D., charged with the use of a fictitious name, was on October 20, 1938, found guilty and placed on probation for a period of five years.

Milton S. McMurtry, M.D., charged in three complaints with alleged abortion, was on October 19, 1938, found guilty and his license to practice was revoked.

Charles L. Orr, M.D., charged with aiding and abetting and use of fictitious name, was on October 18, 1938, found guilty and placed on probation for a period of five years, with the proviso that he cease practice during the period November 1, 1938, to July 1, 1939.

Irving Delphin Thorne (licensed chiropodist), charged with use of fictitious name and aiding and abetting, was on October 18, 1938, found guilty and placed on probation for a period of three years.

The following cases were continued to the next meeting of the Board, to be held in Los Angeles: Edward H. Anthony, M.D., Harry Wilson Boyd, M.D., Melvin B. Huff, M.D., Walter Carl Middleton (drugless practitioner), Milton F. Novotny, M.D., Joseph T. Wrenn, M.D., Thomas D. Wyatt, M.D., and William H. Young, M.D.

News Items

"The State Board of Medical Examiners, meeting here today, reëlected Dr. William R. Molony of Los Angeles as President. Dr. Clark L. Abbott of Richmond and Dr. C. B. Pinkham of San Francisco were reëlected as vice-president and secretary, respectively. Molony has been president since 1933 and Pinkham has been secretary for twenty-five years." (Sacramento *Bee*, October 17, 1938.)

(Continued in Front Advertising Section, Page 21)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.